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26 November 2019

Attention:

Portfolio Committee on Health

Ms Vuyokazi Majalamba

3rd floor,

90 Plein Street, Cape Town 8000,

As per email: vmajalamba@parliament.gov.za

Re: 2019 NHI Bill Commentary

Dear Members of Portfolio Committee on Health

The Board of Healthcare Funders and its members wish to thank the Parliamentary Portfolio Committee on Health for the opportunity to comment on this important bill.

We support the concept of universal health coverage (UHC) as defined by the World Health Organization (WHO), i.e. 'Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship'. As the industry stands upon the precipice of change, the private sector is presented with an opportunity to become involved and to become engaged in the process of consultation, acting proactively with the government in order for the industry to play a meaningful role going forward.

We are pleased to attach BHF's submission, which is in three parts:

1. The first section - Executive summary,

- This section provides a summary of BHF's submission

2. Second part - full commentary and analysis

SERVING MEDICAL SCHEME MEMBERS

DIRECTORS Executive: JK Mothudi (Managing Director), Non-Executive: AK Mia Hamdulay (Chairperson) • A Fourie-van Zyl (Deputy Chairperson) • MR Bayley • M Dlamini (Swaziland) • G Goolab • JH Joubert • NJ Khauoe • M Mahlaba • AV Memela • HL Nhlapo • N Nyathi • C Raftopoulos • SN Sanyanga (Zimbabwe) • HC Schafer (Namibia) • CG Schmidt • H Stephens • MC Wilson • S Martinus • T Makoetlane (Lesotho)

- this section includes BHF's comments and analysis of the bill; taking into consideration the Language used; constitutional anomalies; corporate governance of the NHI Fund; flow of funding; role of provincial and local government; purchaser/provider split *and other detailed commentary on the bill.*

3. Third part – BHF's proposed amendments to the bill

- BHF prepared this section in order to assist the portfolio committee to better understand the nature of the amendments to the NHI Bill that are proposed in its written submission. Some of the changes relate to the wording but other changes are proposed in order to ensure that the systems that are to be created by the bill are effective and efficient and that the Constitution is upheld.
- BHF members have pledged to recognize the critical role of the government in providing for the health needs of the South African population and have committed to working together with the officials of the departments of health and other government agencies in a spirit of fairness, cooperation and constructive engagement within the confines of the law.

Request to present to the portfolio committee

- Further to our submission we would like to request an opportunity to orally present our submission to the portfolio committee on health.

Background - About BHF

BHF's Vision

A member-centric healthcare system that is affordable and accessible to the 'health citizen'

BHF's Mission

A healthcare funding industry anchored on the principles of:

- Social solidarity;
- Affordable access;
- High quality care delivery;
- Financial sustainability; and
- Harnessing collective knowledge, expertise and resources to deliver better value to medical scheme members and healthcare consumers in general.

DIRECTORS Executive: JK Mothudi (Managing Director), Non-Executive: AK Mia Hamdulay (Chairperson) • A Fourie-van Zyl (Deputy Chairperson) • MR Bayley • M Dlamini (Swaziland) • G Goolab • JH Joubert • NJ Khauoe • M Mahlaba • AV Memela • HL Nhlapo • N Nyathi • C Raftopoulos • SN Sanyanga (Zimbabwe) • HC Schafer (Namibia) • CG Schmidt • H Stephens • MC Wilson • S Martinus • T Makoetlane (Lesotho)

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BHF's Role

BHF serves the interests of medical scheme members by representing managed care organisations, healthcare funders (including) medical schemes and their administrators within the healthcare environment.

BHF's core aim is to ensure the sustainability of the healthcare sector by enabling healthcare funders, managed care organisations and administrators to provide accessible, affordable, quality healthcare to their benefitciaries. This is achieved by fulfilling the following key functions:

- Representing and promoting the common interests of the insured medical aid industry in creating access to affordable healthcare;
- Promoting the sectorial attractiveness, competitiveness and sustainability of the insured healthcare sector; and
- Providing economies of scale, to support and enable member schemes, managed care organisation and administrators to deliver value to their members and clients respectively.

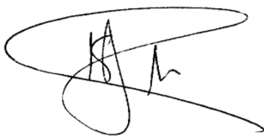
BHF's Guiding Principles

As an organisation BHF is guided by several principles in executing its day-to-day responsibilities. These include:

- Integrity
- Inclusivity
- Openness and transparency
- Relevance: Understanding the context in which our medical schemes operate and meeting their needs
- A sustainable health sector
- Constructive working relationship with policy makers and regulators
- Acting in the best interests of the "health citizens" at all times

Should you need further clarity on our submission, please do not hesitate to contact Dr Rajesh Patel: Head of Benefit and Risk at BHF via email; rajeshp@bhfglobal.com or call 082 7748287. Or you can contact head of stakeholder relations: Zola Mtshiya, via email zolam@bhfglobal.com or call 0658192225.

Yours sincerely



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Analysis and Commentary on the National Health Insurance Bill 2019

SERVING MEDICAL SCHEME MEMBERS

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Executive Summary

1. **BHF Supports UHC**

   BHF supports the concept of universal health coverage (UHC) as defined by the World Health Organization (WHO), i.e. 'Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship'.

2. **NHI is the vehicle to deliver UHC**

   It is necessary to emphasise, however, that national health insurance (NHI) is not UHC. NHI is just one of the mechanisms for achieving the objectives of UHC. Even if UHC is an ideal that can never be fully attained, pursuing it gives direction to a health system for improving access to health care services for those who need them; so it is a valuable concept.

3. **'Friends of NHI'**

   BHF also supports the concept of NHI and has done so since 2008. However, in order for it to work effectively there are certain criteria that must be satisfied. BHF contributed to the first Ministerial Advisory Committee on NHI and had constructive comments and engagements on NHI. When the bill was launched, BHF came out as a 'Friend of NHI'. When making representations, BHF prefers to engage directly with the relevant officials and authorities rather than through the press.

4. **Constitutional rights**

   First and foremost, the NHI Bill must be constitutional, not only in its provisions, but also in its approach to health care financing. The financing system that the bill creates must recognise and respect the constitutional rights of individuals to have access to health care services. It must reflect the government's commitment to protect, respect, promote and fulfil this right, along with the other rights in the Bill of Rights.

5. **Constitutional issues in the bill**

BHF has identified several constitutional issues in the bill that might impede the implementation of NHI. These are:

(1) legal certainty and the rule of law – this relates to the language used in the bill

(2) restrictions on the right of health professionals to choose and practice their profession

(3) restrictions on the right of access to health care services in the bill, including the role of medical schemes to offer parallel benefits cover

(4) the role of provinces and municipalities, the second and third spheres of government in our constitutional system, in health service delivery

6. **The NHI Bill needs to be strengthened on several fronts. These are;**

(1) the language used in the legislation

(2) the constitutional issues raised by the bill

(3) corporate governance of the NHI fund

(4) flow of funding from the fund to providers

(5) The role of provincial and local government in the delivery of health care services

(6) Maintenance of the purchaser/provider split throughout the national health system

7. **Accountability – NHI Fund**

BHF is of the view that to ensure the sustainability and viability of the NHI fund it should be accountable on three different levels. Firstly, it should be accountable to Parliament at the macro level so that Parliament is always kept informed of key issues involving the fund and is able to interrogate it on these issues for the good of the people. Secondly, as provided for in the Public Finance Management Act, the fund is accountable to the Minister of Health as the member of Cabinet under whose portfolio NHI falls. Thirdly the NHI fund should be overseen by a regulator that is able to deal with specifics relating to the fund such as reserving levels, financial risks and their management, financial and other reporting standards and investments by the fund. We recommend that this regulator be the Prudential Authority that resides within the Reserve Bank and that was created in terms of the Financial Sector Regulation Act.

8. **Language used in the Bill**

The bill uses policy language that makes legal interpretation difficult. The language is imprecise and open to different interpretations. There are several unnecessary

repetitions. The transitional arrangements section belongs in policy documentation, not law. Similarly, there are specifics in the bill such as reimbursement models the fund will use to purchase health services that belong in regulation and not in the Act. There are sections of the bill that belong in the National Health Act (NHA) and not the bill. The latter should be purely about the financing side of the purchaser/provider split. It should not contain provisions that relate to the organisation, structure and methods of health service delivery.

9. **User vs Beneficiary**

BHF prefers the term 'beneficiary' to the term 'user' in the Bill. A 'beneficiary' is someone entitled to benefit from the fund. The NHA has already defined the term 'user' as someone who utilises health care services. We suggest that for the sake of clarity and in order to avoid confusion, the term 'beneficiary' be used in the NHI Bill rather than 'user'. All beneficiaries will be 'users' as defined in the NHA, but not all 'users' will be beneficiaries of the fund.

10. **DHMOs and CUPHCs**

The bill does not adequately explain the reason for district health management organisations (DHMOs) or contracting units for primary care (CUPHCs). It also does not set out their role, how they will be governed and to whom they will be accountable. BHF is of the view that DHMOs and CUPHCs are unnecessary and will add an unjustifiable layer of administrative costs to the system.

11. **Strengthening the role of the Provincial departments of Health and Municipalities**

BHF is of the view that existing structures such as provincial departments of health and municipalities should rather be strengthened in their role as providers of health care services. The creation of new entities to play the role of provincial departments of health and municipalities is not only undesirable but constitutionality questionable. The second and third spheres of government are mandated by the Constitution to provide basic services, which must be financed by their equitable share of local revenue. The bill ignores this.

12. The role of the Minister of Health

BHF does not support the extensive role of the Minister of Health as set out in the bill. The board of the fund must be autonomous and independent of political influence in its decisions. The board must have complete authority over and responsibility for the fund. The board must run the fund – not the Minister. The bill gives the Minister the power to potentially veto every significant decision that the board can make. This means that the board cannot be held accountable for its decisions. This is contrary to well-established principles of corporate governance. The board must not be able to escape accountability as a result of a decision by the Minister. The board must be accountable for all of its decisions.

13. Powers of the Board

The board must be free to hire or terminate the services of the CEO of the fund without the approval of the Minister. The board must be able to determine benefits to be covered by the fund without the prior approval of the Minister. The board should be appointed by Parliament and not the Minister because this guarantees a more open and democratic process. The board must play an active hands-on role in the running of the fund, so it needs to be a powerful executive Board that operates full time. It is accountable to the Minister in terms of the Public Finance Management Act (PFMA) but this does not mean it should have to obtain the Minister's input on every decision it makes. Indeed, it can only be accountable to the Minister under the PFMA if it can make decisions independently of the Minister regarding the fund.

14. The Benefits Advisory Committee

The Benefits Advisory Committee must not have the power to determine benefits. This power resides ultimately with the board. The Benefits Advisory Committee must advise the board on benefits to be offered by the fund. No committee contemplated in the bill must have the power to make financial or strategic decisions concerning the fund. This is the responsibility of the board alone. Advisory committees must be just that – advisory.

15. **The corporate structure of the fund**

The corporate structure of the fund must not be set out in the bill. Only the functions which the fund must perform should be set out in the bill. It is for the board to determine the optimal corporate structure of the fund from time to time to remain agile and relevant.

16. **Powers of the consumers to access healthcare services**

The bill should not restrict the power of consumers to access health care services and medicines by saying that the fund is the single payer and single purchaser of health care services and health goods. If people have the means to purchase health care services and health goods outside of the fund, they should be free to do so whether or not they are registered beneficiaries of the fund. Not all health care providers will be contracted to the fund and not everyone will be a beneficiary. There will be circumstances where beneficiaries will need to access health care outside of the fund. The bill does not seem to recognise this possibility in section 2. BHF is opposed to the principle that medical schemes can only offer complementary cover. It is unconstitutional to restrict access to health care services in this way. Medical schemes must be allowed to offer parallel benefit cover (same NHI benefits), that is **regulated** through the yet to be amended Medical Schemes Act and its regulations, if these benefits are considered essential services that will have a positive impact on health status and health outcomes of beneficiaries. This will reduce the financial burden on the NHI fund for those beneficiaries who volunteer to contribute to medical schemes for these parallel benefits.

17. **Healthcare service provider accreditation process**

BHF is opposed to the idea of a separate accreditation process by the fund. It is logistically impractical. Once a health care provider has been certified by the Office of Health Standards Compliance (OHSC) there should be no need for accreditation. The fund, through its contracting criteria, should be able to decide whether or not to contract with a certified provider. The logistics of just certifying every provider have been underestimated in the bill. There are literally tens of thousands of providers. The OHSC needs to be considerably strengthened in order to certify providers for the purposes of NHI. To require an accreditation process on top of certification is likely to delay the implementation of NHI considerably.

18. **Distribution of revenue**

The fund must not act as an alternative agent for the distribution of revenue for health care by simply transferring money to public providers on the basis of budgets. The fund must always make payments on the basis of a contract between the provider and the fund. Payments by the fund must be based on the performance of providers and the quality of care they deliver. The terms of the contract will determine how the fund pays the particular provider with whom it has contracted. Contracting is an essential component of the purchaser/provider split principle endorsed in the White Paper on NHI. It is also essential to ensure that the fund is not faced with unfunded liabilities. The fund should only be required to pay what it can afford for health care services and health products.

19. **Restrictions on the fund's power to invest in the private health care sector.**

There must be a clear dividing line between the fund on the one hand and providers on the other. The fund must not finance the overheads of providers. Providers must manage and fund their own overheads. The fund must only purchase health care services. To avoid a conflict of interest, the fund must not be allowed to deliver health care services or goods to beneficiaries. This means that there must be restrictions on the fund's power to invest in the private health care sector. It should not be able to own hospitals, health technology facilities or pharmaceutical companies, or buy shares in them.

20. **Application of the Competition Act**

The Competition Act should apply to transactions between the fund on the one hand and providers of health care services and health goods on the other. The fund needs to be protected by competition law from the activities of pharmaceutical companies in particular, as recent international experience with a South African manufacturer has shown. It is sufficient to exempt only the fund from the provisions of the Competition Act.

21. **The single exit price**

The single exit price should be the maximum price at which medicines are charged for. Currently it is the only price. The fund should be able to use its monopsony power to negotiate prices that are lower than the single exit price where this is feasible. The negotiated lower price should be made available to everyone.

22. **Medical Schemes Act**

    The proposed amendments to the Medical Schemes Act contained in the bill contradict the provisions of section 33 of the NHI bill. These amendments should therefore be deleted. It is envisaged that the Medical Schemes Act will be reviewed in its entirety. Any proposed changes should be dealt with holistically when the entire Medical Schemes Act is reviewed.

23. There is a document at the end of this commentary in which BHF recommends changes to the wording of the NHI Bill in red. This commentary and the document indicating changes to the wording of the bill in red must both be read. Together they constitute the entirety of BHF's submission on the bill.

Full Commentary and Analysis

Introduction

1. BHF thanks the Parliamentary Portfolio Committee on Health for the opportunity to comment on this important bill. We support the notion of UHC but note that it is not helpful to confuse UHC with the concept of NHI. 'UHC is a set of objectives that health systems pursue; it is not a scheme or a particular set of arrangements in the health system. Keeping this distinction between policy objectives and policy instruments is essential for conceptual clarity and practical decision-making. Making progress towards UHC is not inherently synonymous with increasing the percentage of the population in an explicit insurance scheme.'[1]

2. The NHI fund is a financing mechanism designed to assist in achieving the goal of UHC. It is just one of many tools that must be used towards this goal. The WHO's health economist, Joseph Kutzin, has noted: 'Given the definition of UHC, fully achieving UHC is impossible for any country. Even countries that succeed in attaining universal financial protection have shortfalls in effective coverage. Gaps will always exist because not all individuals in a society can be aware of all of their needs for services, new and more expensive diagnostic and therapeutic technologies continuously emerge, and the quality of care is not perfect in any country. Thus, strictly speaking, no country in the world has achieved universal coverage.'[2] According to Kutzin, even if UHC can never be fully achieved, moving towards it is relevant to all countries. It is justified from a health system performance perspective because it implies progress in attaining the goals of health systems: directly in terms of financial protection and indirectly on the goals of health and responsiveness via the intermediate objectives associated with effective coverage. Put another way, it is more useful to think of UHC as a direction rather than a destination.

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[1] (Kutzin J .'Health financing for universal coverage and health system performance: concepts and implications for policy' *Bulletin of the World Health Organisation* https://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862013000800602)

[2] Kutzin J .'Health financing for universal coverage and health system performance: concepts and implications for policy' Bulletin of the World Health Organisation https://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862013000800602

3. We believe that NHI is an important mechanism to promote UHC, but it is not the only one. Our Constitution contemplates access to health care services in extremely broad terms. It does not define the word 'access'. Therefore 'access' must be interpreted with regard to the wide variety of circumstances in which health care users find themselves. We submit that 'access' in the context of health is a complex concept that has to be considered from a great many angles, including:
   - equity in health service delivery,
   - the way health care providers are regulated,
   - the distribution of health care services,
   - the quality of health and allied services,
   - the nature of clinical standards and guidelines to be used in health service delivery,
   - the financing of health care services,
   - rationing systems and protocols,
   - health service administration,
   - licensing of health establishments,
   - the availability of transport and other infrastructure to and from health establishments,
   - patient education,
   - modes of treatment.

4. Practically speaking not all these angles can be adequately dealt with in a bill whose primary focus is health care financing. Therefore, we stress the importance of considering NHI within the broader framework of the health legislation that surrounds it. The bill effectively abolishes the significant role that provincial governments have hitherto played in the delivery of health care services. The provinces are hardly mentioned in the bill, which apparently seeks to replace them with DHMOs or CUPHCs. The same is true for metropolitan and other municipalities, many of which operate clinics and health care facilities at primary level. These entities have constitutional obligations regarding health and health care services that cannot just be negated in one fell swoop.

5. It is clear from the bill that NHI will not cover everyone for every available health service or product. Therefore, NHI is only part of the solution for achieving UHC. It is important to stress this distinction because in previous policy documents and press statements by government there has been a tendency to confuse UHC with NHI. This causes confusion

in the mind of the public about what NHI is. NHI is a system for financing health care. UHC, on the other hand, emphasises the availability of health care services to all at the time when they need it. The WHO refers to 'health financing for universal health coverage', which clearly indicates that the goal of UHC is much wider than just health care financing. The WHO[3] states: 'Universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the beneficiary to financial hardship.'

This definition embodies three key objectives:

(1) Equity in access to health services: everyone who needs services should get them, not only those who can pay for them;

(2) The quality of health services should be good enough to improve the health of those receiving services; and

(3) People should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

The legislation in South Africa that deals with the first two of these objectives is primarily the NHA, 61 of 2003 (NHA). The NHA regulates equity in access to health care services, modes of health service delivery, locations for the delivery of health services, quality, hygiene and safety standards, licensing of health establishments and the OHSC among others. It essentially covers the first two objectives of UHC cited above. We submit therefore that any new provisions on how health services must be delivered, organised, structured and regulated should be inserted into the NHA in order to avoid confusion between the NHA and the NHI Bill. Provisions that seek to achieve the first two objectives of UHC in the NHI Bill should be restricted to a minimum. The NHI Bill should focus primarily on the financing of health care and thus, objective number three of UHC. This is also consistent with the approach of maintaining the purchaser/provider split in the national health system which the White Paper on NHI endorses.

6. Further on in this document we address in detail the various sections of the bill but we would like to make it clear at the outset that our concerns revolve largely around the following-:

[3] https://www.who.int/health_financing/universal_coverage_definition/en/

- The language used in the legislation
- Constitutional issues
- Corporate governance of the NHI fund
- Flow of funding
- The role of provincial and local government and other existing structures
- Maintenance of a purchaser/provider split

We explain what we mean by this list in the comments below.

Language

7. The language of the bill is confusing and makes it difficult to understand what is intended in many instances. Terms that are used in international and national policy documents such as 'strategic purchasing', 'active purchasing', 'pooling of funds' and 'social solidarity' do not sit well in law. Policy language by nature is more flexible in meaning and open to interpretation. The language of law, by contrast, must be clear, concise, precise and not open to interpretation. Law that is open to interpretation gives rise to misinterpretation and uncertainty. The bill must evoke clarity of thought in the reader and must not be ambiguous in its provisions. For example, section 10(1)(a) says that the fund must 'take all reasonably necessary steps to achieve…the attainment of universal coverage as outlined in section 2'. But section 2 makes no mention of UHC instead it refers to 'universal access to quality health services'. Since the WHO has defined fairly precisely what it means by 'universal health coverage', is the reader assumed to be familiar with the WHO documentation on the subject and must he or she read into section 10(1)(a) the WHO's definition of UHC or must this term be equated with 'universal access to health care services' as mentioned in section 2? The Bill itself does not define the term UHC'. We submit that the achievement of UHC is a policy goal that should not be translated into legislation. It is enough that the goal is stated in policy documents and in the preamble to the bill.

8. Legislative drafting is an art. It requires a grounding in a number of legal and constitutional principles, an understanding of the law on statutory interpretation, proficiency in language and a thorough understanding of how that language can best be used to create law. A legal background on South Africa's legislative framework is also essential as is a detailed knowledge and understanding of the Constitution and constitutional law. These technical aspects are not always appreciated. We submit that the NHI Bill is poorly drafted. It

contains several internal contradictions, shows a poor understanding of the legal principles of legislative drafting and a lack of insight into how language must be used when writing law. It conflates policy principles with legal principles, which causes uncertainty to creep in when reading the bill. There is no recognition that one cannot write all policy into legislation. Some policy should remain just policy. This makes understanding the bill difficult and confusing at times. It is not always clear what the intention is behind certain sections.

9. For example:

- A beneficiary has the right to access health care services within a 'reasonable time period'. What does this mean? How does one tell what this time period is? With reference to what? How can a beneficiary know what is a reasonable time period?

- The Minister of Health is described in section 31 of the bill as 'responsible for governance and stewardship of the national health system' but what are the practical implications of this? Is the bill assigning the Minister a new role? Why is it necessary to say this at all? This provision has no meaning in law. Moreover it has an element of unconstitutionality since the Minister of Health does not act in his own right. He is a member of Cabinet and a member of Parliament and his role is defined by the Constitution. A member of Parliament is not allowed to be employed in any other capacity.

- Section 34(3) says that health workers, health care service providers and persons in charge of health establishments must comply with the provisions of the NHA. Why is this necessary? The NHA is itself law and people must comply with its provisions because they are law. The NHI Bill does not need to prop up the NHA.

- Why is it necessary to stipulate in section 33(3) that the functions of a provincial department must be amended to comply with the purpose and provisions of the bill? If the function and purpose of the provincial departments are set out in the NHA then that is the Act that must be amended. It is totally unnecessary to state this in the NHI Bill. It is a function of the National Executive and Parliament to revise and amend legislation in accordance with national policy and this function

derives directly from the Constitution itself. The drafters of the bill are mixing policy and law.

- Section 39(6) says that the performance of an accredited health care service provider or health establishment must be monitored and evaluated, and appropriate sanctions must be applied where there is a deviation from contractual obligations 'as per the law'. What does this mean? Contracts have their own sanctions built in. What law is section 39(6) referring to? The NHI Bill? Criminal law? Regulations under the NHI bill? Contracts by their nature are flexible and their terms are decided and agreed upon by the contracting parties. If all of the terms of a contract are dictated by regulations, then it is no longer a contract because what the parties want is irrelevant. The terms of the contract say what happens when a party acts in breach. Furthermore, when drafting legislation, one does not use phrases such as 'per the law'. They are too vague. In legislation it is unnecessary to require adherence to another law because that other law, whatever it is, already applies.

- There is a contradiction between section 33 of the bill (which says that the Minister will decide, when NHI has been fully implemented, through regulations in the Gazette when medical schemes can offer only complementary cover) and the schedule of the bill which amends the Medical Schemes Act to say that medical schemes can only provide complementary cover. If the Medical Schemes Act is amended in the manner contained in the schedule to the bill, then section 33 is unnecessary because when the amendments to the Medical Schemes Act come into effect is when medical schemes will only be able to offer complementary cover. BHF recommends that the proposed amendments to the Medical Schemes Act in the schedule to the bill be deleted as they are unnecessary in the light of section 33.

- There is a similar contradiction between section 3(5) of the bill and the proposed amendments to the Competition Act in the schedule to the bill. The proposed amendments to the Competition Act exempt the fund from application thereof. It is therefore unnecessary to say in section 3(5) that the Competition Act will not apply to transactions concluded in terms of the NHI Bill. In any event, BHF believes that it is not appropriate to exempt all transactions in terms of the NHI Bill from

the Competition Act because the NHI fund needs to be protected from anti-competitive conduct on the part of suppliers. It should only be the fund that is exempted from the Competition Act, not all transactions in terms of the Act.

Constitutional Issues

10. The rule of law is a founding value of the Constitution. Some of the constitutional principles underlying legislative drafting are:
    - Law or conduct inconsistent with the Constitution is invalid and the obligations imposed by the Constitution must be fulfilled.
    - The rule of law requires that legislation must be stated in a clear, accessible and reasonably precise manner, and that there must be a rational relationship between a scheme adopted by a legislature and the achievement of a legitimate government purpose
    - The purpose underlying the doctrine of vagueness is to 'indicate with reasonable certainty to those who are bound by the law what is required of them so that they may regulate their conduct accordingly'. Therefore, legal certainty is a requirement of the rule of law.
    - Legislation must satisfy the test for rationality.
    - Legislation must satisfy the test of reasonableness.
    - No legislative measure may limit an entrenched right except in the manner permitted by our supreme law.
    - The doctrine of legality is an incident of the rule of law.
    - All law in South Africa must satisfy the test for rationality.
    - A limitation of constitutional rights must satisfy the requirements of the Constitution by being reasonable.

11. While the stated intention behind NHI is to increase access to health care services, particularly for the vulnerable and the poor, one cannot ignore the manner in which the bill is written and the consequences, unintended or intended, of the wording used. The wording must match the intention of *increasing* access to health care services for everyone. To the extent that it may decrease such access for anyone, it is unconstitutional.

12. The Constitution states that *everyone* has a right to have access to health care services – not just the poor. In *Government of the Republic of South Africa and Others v Grootboom and Others* (2001) (1) SA 46 (CC) para 36 the Constitutional Court said:

    In this regard, there is a difference between the position of those who can afford to pay for housing, even if it is only basic though adequate housing, and those who cannot. For those who can afford to pay for adequate housing, the State's primary obligation lies in unlocking the system, providing access to housing stock and a legislative framework to facilitate self-built houses through planning laws and access to finance. Issues of development and social welfare are raised in respect of those who cannot afford to provide themselves with housing. State policy needs to address both these groups.

13. The fact that access is a multifaceted concept that must consider the context in which access must be facilitated is evident from the judgement of the Constitutional Court in *Grootboom*. The decision of the Constitutional Court in *Grootboom* makes it clear that a right to access to health care services does not mean only that the State alone must purchase health care for everyone. It means that the State must *facilitate* access in a variety of contexts taking into account the situation of all the various groupings within society, not just the poor and vulnerable. The World Medical Association recognises that 'access is itself multidimensional, and is constrained by factors including health human resources, training, finance, transportation, geographical availability, freedom of choice, public education, quality assurance and technology'.[4]

14. The Constitution requires the State to *protect*, respect, promote and fulfil the rights in the Bill of Rights. This means that the State must protect the rights to access that people already have. The right of access to health care is much wider than the right to obtain health care through the State or from the State. It includes the right to purchase health care from the private sector if one can afford it. The purchasing power of the consumer is a legitimate means of access to health care even if it is not always the best form of access. People must have the right to do what they want with their own money provided their actions are lawful. It should not be unlawful for people to purchase health care services should they choose to do so. The NHI Bill makes it unlawful for people to purchase health care services that are covered by NHI except in very limited circumstances. This is an infringement of their constitutional right of access to health care services, the right to

[4] https://www.wma.net/policies-post/wma-statement-on-access-to-health-care/

dignity and the right to bodily and psychological integrity which includes the right to security in and control over one's body. It is also an infringement of the right to freedom of association. If a person does not want to use an NHI-accredited health care provider to obtain services covered by NHI, he or she should have the option to obtain them elsewhere at his or her own expense. The right of a person to purchase health care services, medicines and health care products should not be restricted by the NHI Bill.

15. If people covered by NHI have the right to receive health care services within a reasonable time period (whatever that time period may be) and do not receive services within that reasonable time period, what is their remedy? Time periods are crucial when it comes to access to health care. Time is integral to the concept of access. Cancer patients who have to wait too long for treatment run the risk of dying because cancer is a progressive disease. In 2018 it was reported that there was a backlog in KwaZulu-Natal province alone in respect of waiting times for radiation oncology exceeding the recommended 6-8 weeks; 8000 cancer patients were affected.[5]

16. There are many other progressive health conditions that must be treated timeously in order to obtain optimal benefit. BHF submits that persons who do not receive health care within a reasonable time under NHI must have the option to purchase that health care themselves or through a medical scheme - even if it is covered by NHI.

17. Section 36 of the Constitution states that the rights in the Bill of Rights may be limited to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose and less restrictive means to achieve the purpose.

[5] https://www.iol.co.za/dailynews/kzn-has-biggest-cancer-patient-backlog-17229453. See also 'Death and Dignity: How KZN Strips Cancer Patients of their Pride' March 26 2018 https://bhekisisa.org/article/2018-03-26-00-death-and-dignity-how-kzn-strips-cancer-patients-of-their-pride/. In May 2018 the MEC for Health in KZN had to appear before the Human Rights Commission. He had to produce documentation and information regarding the ongoing oncology crisis. Dhlomo's appearance came after 10 months of consultations with the province's health department in this regard. In a statement the Commission said, 'It remains concerned at the lack of meaningful progress.' And that 'it has noted numerous reports that many cancer patients still lack access to timely and appropriate oncology health care and that some may have already died.'https://www.sahrc.org.za/index.php/sahrc-media/news/item/1334-kzn-mec-appears-before-sahrc-over-oncology-crisis

18. Our constitutional democracy is founded on, among other values, the 'supremacy of the Constitution and the rule of law'. The very next provision of the Constitution declares that the 'Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid'. And to give effect to the supremacy of the Constitution, courts 'must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency'. This commitment to the supremacy of the Constitution and the rule of law means that the exercise of all public power is now subject to constitutional control. The exercise of public power must therefore comply with the Constitution, which is the supreme law, and the doctrine of legality, which is part of that law. (*Affordable Medicines Trust and Others v Minister of Health and Others* 2006 (3) SA 247 (CC))

19. One of the most fundamental rights provided by the Constitution is found in section 11 and reads that everyone has the right to life which, along with the right to human dignity, must be valued above all other rights.[6] A provision in the NHI Bill that adversely impacts on the right to life must meet the criteria in section 33(1)(a)(ii) of the Constitution on the justifiable limitation of rights. A provision of the bill that impedes a person's ability to seek and obtain health care impacts on his right to life because access to health care can be a matter of life and death. But the Constitution does not construe the right to life as narrowly as life and death. It also embraces the idea of *quality* of life – a notion that is central to the right of access to health care services.

20. The right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the center of our constitutional values. The constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society.[7] Health care affects the quality of a person's life. The constitutional right to life is not only about the right to exist but the right to experience quality of life. The right of access to health care services therefore supports the right to life.

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[6] *S v Makwanyane [1995] ZACC 3;* 1995 3 SA 391 (CC) para 214.

[7] *S v Makwanyane [1995] ZACC 3;* 1995 3 SA 391 (CC) para 326.

21. In *S v Makwanyane* the Constitutional Court emphasised the idea of a life worth living by adding that the right to life could possibly impose a duty on the state to create conditions which will enable all persons to enjoy a life worth living.[8] In *Makwanyane* the Constitutional Court said that the right to life is one of the most important rights and the source of all other rights, and that these rights must be valued, and the State must demonstrate this in everything that it does. The NHI Bill threatens a form of access to health care services that some people already have. It is submitted that this affects the constitutional rights of those people. One cannot promote the rights of the poor and unemployed at the expense of the rights of others.

22. The rights to human dignity and life are entwined. The right to life is more than existence, it is the right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity. The Constitutional Court[9] has said that human dignity is a central value of the objective, normative value system that must guide the development of all areas of law. Health is essential for both life and human dignity. Access to health care services upholds the right to human dignity. A reduction in access to health care services adversely affects the right to dignity. If the NHI Bill does not give people the freedom to acquire health care services from all available lawful sources then it is limiting the right of access and impacting on the rights to life and human dignity.

23. The right to freedom is the right of individuals not to have 'obstacles to possible choices and activities' placed in their way by the State.[10] Freedom means more than just physical liberty.[11] The National Health Bill must enable access to health care without unduly restricting the rights of everyone to freedom and security. This includes the right to bodily and psychological integrity. People must be free, if they have the resources, to procure their own health care. This is integral to their right to bodily and psychological integrity. If the provider they wish to use is not contracted to the NHI fund, they must be free to

[8] *S v Makwanyane [1995] ZACC 3*; 1995 3 SA 391 (CC) para 353.

[9] *Carmichele v Minister of Safety and Security 2001 4 SA 398 (CC) para 56.*

[10] *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others (CCT5/95) [1995*] ZACC 13; 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (6 December 1995)

[11] *AB and Another v Minister of Social Development* (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016)

purchase health care from that provider if they so choose, regardless of whether the service is covered by NHI. If the medicine they need is not available from an NHI-contracted supplier, they must be free to purchase that medicine from another source not linked to NHI. If a person has the means to purchase health care, prohibiting him by law from doing so adversely impacts on his right to bodily and psychological integrity. He is disempowered as an individual. His human dignity is diminished.

24. As a prerequisite for the limitation of rights entrenched in Chapter 3 of the Constitution, section 33(1)(a)(ii) provides that such limitation shall be permissible only to the extent that it is 'justifiable in an open and democratic society based on freedom and equality'.[12]

25. A right cannot be lightly limited. A law may legitimately limit a right in the Bill of Rights if it is a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. The fact that a person is forced to contribute to the NHI fund through a tax should not mean he should be forced to access that health care only through the fund even if he can achieve better access through other means.

26. Considering the foregoing, the NHI Bill contains a number of anomalies that are objectionable on constitutional grounds. While the Bill's wording may, on the face of it, seem to be constitutional, one must read it with an understanding of the practical implications of its wording for beneficiaries and non-beneficiaries of the NHI system. BHF submits that the bill is open to attack due to the following constitutional anomalies.:

The First Constitutional Anomaly

27. The first instance of restriction of access to health care services is implied by the single purchaser/single payer provision in section 2. It implies that health care providers who are not accredited by, and do not contract with, the fund cannot be paid for their services by *anyone*. This is not restricted only to services covered by NHI. The bill says the fund is the *single* purchaser and *single* payer for all health care services not just those covered by the

[12] *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (6 December 1995)

fund. 'Single' means 'only'. Only the fund can purchase and pay for health care services. Therefore, providers who are not accredited and contracted by the fund must render their services for free to their patients? What is the intention of the wording of section 2? If it means that only the fund can purchase and pay for health care services, then this interferes with the right of health care providers in section 22 of the Constitution to freely choose their occupation, trade or profession.

28. The Constitutional Court has held that section 22 embraces both the right to choose a profession and the right to practice the chosen profession. Section 2 interferes with the right of providers to practice their profession (*Affordable Medicines Trust and Others v Minister of Health and Others* 2006 (3) SA 247 (CC)). Health care providers cannot force the fund to accredit them or contract with them. If the fund does not, then according to section 2 of the NHI Bill, they will be unable to practice their profession because only the fund can purchase and pay for health care services. This is clearly unreasonable and a violation of section 22 of the Constitution.

29. The Constitutional Court said regarding the rights in section 22 of the Constitution that what is at stake is more than one's right to earn a living, important though that is. Freedom to choose a vocation is intrinsic to the nature of a society based on human dignity as contemplated by the Constitution. One's work is part of one's identity and is constitutive of one's dignity. Every individual has a right to take up any activity which he or she believes himself or herself prepared to undertake as a profession and to make that activity the very basis of his or her life. And there is a relationship between work and the human personality. 'It is a relationship that shapes and completes the individual over a lifetime of devoted activity; it is the foundation of a person's existence'. (*Affordable Medicines Trust and Others v Minister of Health and Others* 2006 (3) SA 247 (CC)

The Second Constitutional Anomaly

30. The bill creates legal uncertainty. Legal uncertainty is contrary to the constitutional principle of the rule of law. Not only is the single purchaser/single payer provision in section 2 not in keeping with the Constitution, it is contradicted by other sections. These other sections state:
    - a beneficiary has a right to purchase health care services that are not covered by the fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, any other private health insurance scheme or out-

of-pocket payments as the case may be (section 6(o). Note that a 'user' is defined as someone who is registered with the fund in terms of section 5. Section 6(o) suggests that the fund is not the single payer and single purchaser of health care services because it says that a 'user' can purchase health care services not covered by the fund. It allows that medical schemes can purchase and pay for certain health care services. This nullifies the notion that the fund is the *single* purchaser and payer of health care services. What about persons who are not users, i.e. those who have not registered with the fund? They also have a right to purchase and pay for health care services. But according to section 2 they cannot, because the fund is the single purchaser and single payer. *Everyone*, not just users, should have the right to purchase *all* health care services if they choose to do so and have the means. Section 6(o) should therefore be deleted or amended to read. 'Everyone has the right to purchase health care services, whether or not they are covered by the fund'.

- Section 8(2) states that *a person or user* must pay for health care services rendered directly through a voluntary medical insurance scheme or through any other private insurance scheme if that person or user:
  (a) is not entitled to health care services purchased by the fund;
  (b) fails to comply with referral pathways prescribed by a health care service provider or health care establishment;
  (c) seeks services that are not deemed medically necessary by the Benefits Advisory Committee; or
  (d) seeks treatment that is not included in the formulary.

  It therefore acknowledges that a medical scheme can be a payer and a purchaser of health care services. Once again this means that the fund cannot be the single purchaser and single payer as stated in section 2.

31. Section 8(2) acknowledges those who are not registered as *users* with the fund. However, it requires them to purchase their health care through a medical scheme or other private insurance. They are not allowed to purchase it out of their own pockets. That is what section 8(2) says. This is so unconstitutional that it cannot possibly be the intention of the drafters of the bill. A person should not be obliged to be a member of a medical scheme or to buy an insurance policy before they can purchase health care services. They should be free to choose the manner in which they obtain health care services where they have

the means to do so. They must be able to pay out of their own pockets, yet section 8(2) does not say this.

32. Legal certainty is a requirement of the rule of law and is entrenched in the Constitution. Section 8(2), when read with section 2, creates legal uncertainty. This is contrary to the rule of law and the Constitution.

33. In terms of the bill only beneficiaries are entitled to benefits from the fund. A *person* who is not a *beneficiary* must fulfil all his health care needs in some other way. A *person* who is not a *beneficiary* must not be obliged to comply with the referral pathways created in terms of the NHI Bill in order to obtain health care services. Only *beneficiaries* must be obliged to comply with referral pathways. And even they may not always be able to do so. If a *beneficiary* does not comply with a referral pathway, he must be able to purchase health care services with his own funds or with medical scheme cover, even if those services are covered by the fund. But then this means that medical schemes must be able to offer more than just complementary cover as stipulated in section 33. Otherwise the *beneficiary* who does not comply with a referral pathway is effectively denied access to health care services covered by the fund. BHF cannot stress enough that the freedom of everyone, if they have the means, to purchase health care services to meet their needs must not be interfered with by the bill. The uncertainty created by section 2, section 6(o), section 8(2) and section 33 when read together is contrary to the rule of law and therefore the Constitution. The rights of beneficiaries and others must be absolutely clear.

The Third Constitutional Anomaly

34. There is a third constitutional anomaly in the NHI Bill. It does not permit the provinces to purchase health care services. If the NHI is the single purchaser/single payer of/for health care services, then provinces cannot purchase health care services. This flies in the face of the constitutional duty of provinces, a part of the State, to ensure the progressive realisation of the right of access to health care services. It does not help to state in section 3(4) that it does not 'in any way amend, change or alter the funding and functions of any organ of state in respect of health care services until legislation contemplated in sections 77 and 214, read with section 227 of the Constitution and any other relevant legislation have been enacted or amended'. The Constitution itself cannot be amended by the contemplated legislation.

35. The Constitution itself dictates that provinces must provide 'basic services'. The Constitution also requires municipalities to provide basic services. These basic services include certain health services. If section 2 comes into operation before this other legislation has been enacted or amended, then what happens? There is uncertainty and a likelihood of confusion. Sections 77 and 214 deal with money bills and the equitable allocation of revenue. They do not provide for amendments to the Constitution. How can the reader of the bill know what the 'other relevant legislation' is that must be amended? Is it referring to the amendments of the NHA and other contained in the schedule to the bill or is it referring to other legislative amendments that at this stage have not been included? Section 21 of the NHA is being amended to reflect that health care services are delivered 'through' provinces as opposed to 'by' provinces. Why? Because the bill is taking the line that provinces will no longer deliver health care services themselves? This is also apparent from the proposed amendments to section 25 of the NHA in the schedule to the bill. But they have a constitutional mandate to deliver basic services. These services include health care services and at the very least one would say that basic health services are primary health services.

36. The provinces are the second tier of government. The Constitution does not oblige only the national government to ensure the progressive realisation of the right of access to health care services. Section 27 refers to 'the State'. The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. The provinces are part of the State. The State does not consist only of national government.

37. By and large, the provinces own the public health infrastructure. They also form part of the State. They therefore also have a constitutional obligation in their own right to protect, respect, promote and fulfil the rights in the Bill of Rights (section 7(2) of the Constitution). The national government does not have the power to relieve them of this obligation through legislation because it is a constitutional obligation. All legislation is subject to the Constitution. Section 41(1)(g) of the Constitution states that all spheres of government and organs of state within each sphere must exercise their powers and perform their functions in a manner that does not encroach on the geographical, *functional* or *institutional* integrity of government in another sphere. They must also not assume any

power or function except those conferred on them in terms of the Constitution (Section 41(1)(f)).

38. Section 2 of the NHI Bill reduces the provinces to the level of health care service providers at best and bypasses them altogether at worst. They are not allowed to purchase or pay for health care services because the NHI fund is the *single* purchaser/*single* payer. This means that provinces will not be able to contract with private health care providers to provide health care services where there is a need for such services and the province itself does not have the resources to provide for it. Also, persons other than beneficiaries will still look to the provinces for health care services. How must the provinces provide for them? Section 31(3) states that 'without derogating from the Constitution or any other law, the functions of a provincial Department must be amended to comply with the purpose and provisions of this Act'. The drafters of the Act clearly included this in an attempt ensure that the bill is constitutional, but we submit that this does not help if other provisions are in fact unconstitutional. If the other provisions require the unconstitutional amendment of the role of the provinces, then section 31(1) does not save it from unconstitutionality.

39. Section 214 of the Constitution mandates national legislation that must provide for the equitable division of revenue raised nationally among the national, provincial and local spheres of government. This legislation must take into account *inter alia* the need to ensure that the provinces and municipalities are able to provide basic services and perform the functions allocated to them. These basic services include health care services and, at the very least, mean primary health care services and emergency medical treatment as envisaged in section 27(3) of the Constitution. Section 4 of the NHA requires that the State provide pregnant and lactating women and children below six years of age with free primary health care. It also requires that the State provide free primary care to *all* persons who are not members of medical schemes. The State includes provincial departments of health.

40. Furthermore, section 4 of the NHA refers to all pregnant and lactating women and children under six except those covered by medical schemes. When NHI comes in, not all pregnant and lactating women and other adults, and children under 6, will necessarily be *beneficiaries.* They may be temporary residents, asylum seekers or illegal foreigners. The provincial governments have to supply them with free primary care. A considerable

number of these people may not be beneficiaries for one reason or another. The legislation contemplated in section 214 of the Constitution is the annual Division of Revenue Act (DORA). It may only be enacted after any recommendations of the Financial and Fiscal Commission have been considered. The Commission is independent and subject only to the Constitution and the law. The Commission makes recommendations to organs of state on financial and fiscal matters in accordance with section 220 of the Constitution.

41. Section 49(2) of the NHI Bill refers to 'general tax revenue including the shifting (sic) funds from the provincial equitable share and conditional grants into the fund'. This means that the provinces' equitable share for health care services will no longer be paid to the provinces. The provinces own the public health establishments in the province and they employ health care professionals and management staff to operate them. The provinces therefore have operating expenses in relation to health care. The NHI Bill in one small ill-considered sentence removes the equitable share for health care services from the provinces and mandates that these funds be paid into the NHI fund. This effectively creates an unfunded mandate for the provinces.

42. Section 227(3) of the Constitution states that a province's equitable share of revenue raised nationally must be transferred to the province promptly *and without deduction*, except when the transfer has been stopped in terms of section 216.

43. BHF is concerned that there is a risk that the provincial governments will attempt to raise money through provincial taxes if they cannot meet their unfunded mandate. In fact, it could be argued that a provincial government is obliged to impose provincial taxes if it cannot fund its constitutional mandate. Section 227 (2) of the Constitution states that additional revenue raised by provinces or municipalities may not be deducted from their share of revenue raised nationally, or from other allocations made to them out of national government revenue. Equally, there is no obligation on the national government to compensate provinces or municipalities *that do not raise revenue commensurate with their fiscal capacity and tax base*. Section 227(4) of the Constitution stipulates that a province must provide for itself any resources that it requires, in terms of a provision of its provincial Constitution, that are additional to its requirements envisaged in the Constitution. Section 228 of the Constitution allows the provinces to impose:

(a) taxes, levies and duties other than income tax, value-added tax, general sales tax, rates on property or customs duties; and

(b) flat-rate surcharges on any tax, levy or duty that is imposed by national legislation, other than on corporate income tax, value-added tax, rates on property or customs duties.

44. The population of South Africa is already overburdened with taxes. If the provinces decide to impose taxes on their residents in addition to national income tax, people will not be able to afford to live.

45. The national Department of Health does not own and administer public health establishments. The provincial governments do. This is by virtue of a Proclamation by President Mandela in terms of the Constitution back in 1994. Therefore, 'the State' in this section means the provinces. The NHI Bill does not amend this section 4 of the NHA. The purchaser/provider split principle which was endorsed by the White Paper on NHI is being violated by these provisions. Public providers of health care, just like private providers, must manage their own costs and be accountable and responsible for their own budgets. The NHI fund cannot just bypass the provincial governments and remove the part of their equitable share for health care services. The NHI Bill seems to be bypassing the provinces in favour of DHMOs. These DHMOs are established as *national* and not provincial government components in terms of the bill. BHF is of the view that the constitutional role of the provinces in the provision of health care services is being negated by the NHI Bill. This is a constitutional issue. The Constitution sits above all other law. It cannot be amended either directly or indirectly by the NHI Bill. To the extent that the latter is inconsistent with the former, it is invalid in terms of section 2 of the Constitution.

46. The NHI fund must purchase health care from public providers just as it must purchase health care from private providers. It must not *finance* public health care providers. It must purchase health care services from them. There is a difference. If the fund finances health care providers then there is no purchaser/provider split. The NHI fund must not usurp or contradict:

- the constitutionally mandated mechanisms of the DORA;
- the concept of the equitable share; and

- the role of the Financial and Fiscal Commission for the distribution of revenue to the provinces.

The Fourth Constitutional Anomaly

47. The NHI Bill unreasonably and unjustifiably restricts access to health care services for certain members of the population. It is constitutionally impermissible to restrict or impede access to health care services, except in a manner that is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom and considering all relevant factors including –

    (a) the nature of the right;

    (b) the importance of the purpose of the limitation;

    (c) the nature and extent of the limitation;

    (d) the relation between the limitation and its purpose; and

    (e) less restrictive means to achieve the purpose.

48. There is much more at stake in limiting the right of people to have access to health care services only through the NHI fund than just the right of access to health care services. As stated previously, there are other constitutional rights involved including the right to life, the right to human dignity, the right to freedom of association, the right to bodily and psychological integrity and the right to freely choose and practise one's trade, occupation or profession. There can be no reasonable justification for preventing a person from using their own resources to exercise these rights. To the extent that the NHI Bill does so, it is unconstitutional. While the bill purports to improve access to health care services, it actually restricts it in some cases.

49. Section 2 provides that the NHI fund will serve as the 'single purchaser and single payer of health care services'. It does not limit this only to health care services covered by the fund. It says 'health care services'. This means that private individuals may not purchase or pay for *any* health care services themselves. However, it goes even further than this. By using the word 'single' it is stating that *no-one* apart from the NHI fund may purchase

any health care services in South Africa or pay for them. This means that provincial governments, medical schemes, non-governmental organisations and private individuals may not purchase or pay for any health care services. Is this reasonable? BHF submits that it is not. The word 'single' in relation to 'purchaser' and 'payer' must be deleted. The word 'national' could be used instead of 'single'.

50. If a person wants to go down to the local pharmacy to purchase paracetamol for her headache, should she not have the power to do so even though paracetamol is covered by the NHI? If a child is ill in the night, should the parents not have a right to take her to the nearest available health facility, whether or not that facility is contracted to the NHI? If a beneficiary's specific asthma medication is not included on the Essential Drugs List for NHI, should that beneficiary not be able to get a prescription for it from her health care provider and purchase it either out of her own pocket or through her medical scheme?

51. If a patient is refused renal dialysis by the NHI fund due to rationing criteria, should he still be able to purchase it from the private health sector in his personal capacity or through a medical scheme? (see *Soobramoney v Minister Of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC)). If a person cannot afford to take time off work to sit all day at a clinic, why should he not be able to make an appointment to see a GP and avoid the queue if he can pay for it? The devil is in the detail. One must always consider what a law means in practical terms. The practical implication of the NHI fund being the 'single' purchaser and 'single' payer of health care services in South Africa is that no-one else may purchase health care services, whether or not they are covered by NHI. That is what the wording of section 2 says. Whether or not this is in fact the intention is difficult to determine because there are other sections that contradict section 2 (see further below).

52. People will always need to be able to use their own resources to purchase and pay for health care because the NHI fund will never be able to cover everything. Even where the NHI does cover certain health care services there may be problems that result in lack of access, e.g. stockouts, breakdown of medical equipment, lack of specialists, unavailability of doctors, not enough beds. It is a fact of life that resources for health care will *always* be limited under NHI. Section 2 by its wording is therefore an unconstitutional restriction on access to health care services by those with the means to pay for them. The notion of a single payer/single purchaser belongs in policy statements, not in law. People are bound by law. They are not bound by policy. Ideology belongs in policy not law. The Constitution

is the only law that contains ideology and that is because it is the supreme law. Other law must be precise and unambiguous and in accordance with the Constitution. It may be the policy intention for the fund to become the 'main' purchaser/single payer for health care services in South Africa but it is not lawful to legislate this using the word 'single' because this unjustifiably restricts the public's constitutional rights of access to health care services. For this reason we recommend the use of the word 'national' instead of 'single'.

53. Section 2 assumes that *every* provider will be willing to contract with the fund and will be accredited by the fund, that *every* person who is entitled to benefits under the fund will register with the fund and that *every* health care need of the beneficiaries of the fund will be met by the fund. It is only when these conditions are fulfilled that the fund could be the *single* purchaser and the *single* payer of health care services. This is clearly unrealistic. The NHI fund can never be the *single* purchaser/*single* payer for health care services in South Africa because this would be unconstitutional.

54. It is recommended that medical schemes are allowed to offer parallel benefit cover (same NHI benefits), that is **regulated** through the yet to be amended Medical Schemes Act and it regulations, particularly if these benefits are considered to be essential services that will have a positive impact on health status and health outcomes of beneficiaries. This will reduce the financial burden on the NHI fund for those beneficiaries who volunteer to contribute to medical schemes for these parallel benefits.

55. The constitutional anomalies highlighted above should raise significant concern. These anomalies may impede the implementation of the NHI fund. BHF recommends that Parliament seek opinions and inputs from independent constitutional expertise during this review process.

Corporate Governance of the NHI fund

56. The bill is weak on corporate governance of the fund. Sound corporate governance is critical for preventing mismanagement of assets, corruption, inefficiency, illegality, unethical conduct, abuse of the fund's resources and the collapse of the fund. The purpose of the King Code on corporate governance is to:

- create an ethical culture in organisations,
- improve their performance and increase the value they create,
- ensure there are adequate and effective controls in place,
- build trust between all stakeholders,
- ensure the organisation has a good reputation,
- ensure legitimacy.

57. The King Code IV applies to all organisations, including public institutions and State-owned enterprises, in South Africa. It has been developed over a long period of time by experts in law and corporate governance and is recognised internationally. It describes ethical leadership as involving the anticipation and prevention, or otherwise amelioration, of the negative consequences of the organisation's activities and outputs on the economy, society and the environment and is characterised by:
    - Integrity
    - Transparency
    - Competence
    - Responsibility
    - Accountability
    - Fairness.

58. It describes effective leadership as being results-driven and is about achieving strategic objectives and positive outcomes. King IV states that the primary governance role and responsibilities of a board are to:
    (i) Steer and set strategic direction with regard to the organisation's overall strategy and the manner in which specific governance areas are approached;
    (ii) Approve policy and planning that gives effect to the strategy;
    (iii) Oversee and monitor implementation and execution by management;
    (iv) Ensure accountability for performance by among others reporting and disclosure.

59. King IV contains 16 principles that are applicable to the fund. These are:
    (1) The governing body should lead ethically and effectively;
    (2) The governing body should govern the ethics of the organisation in a way that supports the establishment of an ethical culture;

(3) The governing body should ensure that the organisation is and is seen to be a responsible corporate citizen;

(4) The governing body should appreciate that the organisation's core purpose, its risks and opportunities, strategy, business model, performance and sustainable development are all inseparable elements of the value creation process;

(5) The governing body should ensure that reports issued by the organisation enable stakeholders to make informed assessments of the organisation's performance, and its short, medium and long-term prospects;

(6) The governing body should serve as the focal point and custodian of corporate governance in the organisation;

(7) The governing body should comprise the appropriate balance of knowledge, skills, experience, diversity and independence for it to discharge its governance role and responsibilities objectively and effectively;

(8) The governing body should ensure that its arrangements for delegation within its own structures promote independent judgement, and assist with the balance of power and the effective discharge of its duties;

(9) The governing body should ensure that the evaluation of its own performance and that of its committees, its chair and its individual members, support continued improvement in its performance and effectiveness;

(10) The governing body should ensure that the appointment of, and delegation to, management contribute to role clarity and the effective exercise of authority and responsibilities;

(11) The governing body should govern risk in a way that supports the organisation in setting and achieving its strategic objectives;

(12) The governing body should govern technology and information in a way that supports the organisation setting and achieving its strategic objectives;

(13) The governing body should govern compliance with applicable laws and adopt non-binding rules, codes and standards in a way that supports the organisation's being ethical and a good corporate citizen.;

(14) The governing body should ensure that the organisation remunerates fairly, responsibly and transparently so as to promote the achievement of strategic objectives and positive outcomes in the short, medium and long term;

(15) The governing body should ensure that assurance services and functions enable an effective control environment, and that these support the integrity of information for internal decision-making and of the organisation's external reports;

(16) In the execution of its governance role and responsibilities, the governing body should adopt a stakeholder-inclusive approach that balances the needs, interests and expectations of material stakeholders in the best interests of the organisation over time.

While we acknowledge that the NHI fund will be subject to the Public Finance Management Act, not all of these points are covered in it.

The Minister of Health, as a single individual, is incapable of satisfying the requirements for good corporate governance set out in King IV. Only a board can do this. The governing body of the fund must be the board of the fund, not the Minister. It is therefore unfortunate that the NHI Bill effectively allows the Minister the power to veto every significant decision of the board.

60. The characteristics of an accountable organisation are:

(1) It serves a purpose. NHI must strive to achieve a purchaser/provider split to promote equitable distribution of funding based on health needs, and to promote accountability in health care delivery (paying for performance).

(2) The board takes ownership of its decisions and shows clear leadership.
   (a) Accountability of the fund is unitary, i.e. to one authority only (not the board and the Minister as is the case in the NHI Bill).
   (b) Accountability is not delegated or reduced; therefore, the board is fully responsible. (If all decisions of the NHI board must be taken 'in consultation with' the Minister, then how can the board be held accountable for its decisions?)

(3) The organisation and its board are independent of external influences and bias.
(4) The board is in full control of the organisation's operations.
(5) The board has free control over the organisation and is able to navigate competing priorities and challenges. It is agile and responsive to the changing environment.
(6) The board is able to be innovative in dealing with the challenges.

61. The Conduct of Financial Institutions (COFI) Bill, which is very well drafted, contains principles relating to culture and governance for financial institutions. We hardly need to

point out that the fund will be a massive financial institution. We recommend that similar provisions are included in the NHI Bill to ensure proper corporate governance of the fund by the board. (The COFI Bill will not apply to the fund.) The COFI Bill says that a financial institution must:

(a) conduct its business with integrity;
(b) conduct its business at all times honestly, fairly, with due skill, care and diligence in the best interests of financial customers (in the case of NHI this would be beneficiaries)
(c) organise and control its affairs responsibly and effectively;
(d) maintain adequate financial and other resources;
(e) avoid, or where avoidance is not reasonable, manage, mitigate and disclose conflicts of interest;
(f) deal with the authorities in an open and co-operative manner;
(g) comply with conduct standards;
(h) have due regard for the interests and fair treatment of beneficiaries, including conducting its activities transparently and with due regard for the information needs of beneficiaries;
(i) ensure that its governing body is accountable.

62. A financial institution must adopt, document, implement and monitor the effectiveness of a governance policy that ensures adherence to the principles listed above. The governance policy must be proportionate to the nature, scale and complexity of the activities and the risks of the financial institution.

63. The COFI Bill requires that a financial institution must have a documented conflict of interest policy to promote the effective oversight of conflicts of interest and to ensure fair treatment of beneficiaries. It must also have an objective monitoring and compliance process for implementing the policy and assessing its effectiveness in relation to stated objectives and potential risks.

64. The NHI Bill should include provisions on corporate governance similar to those in the COFI Bill. BHF submits that there are major accountability issues with regard to corporate

governance of the fund. These are caused by the fact that the bill requires virtually every significant decision of the board to be made in consultation with the Minister. This will hamper the board's ability to govern the fund effectively because it allows the Minister to intervene in board decisions. The board of the fund must not be subjected to political intervention in this manner. Board decisions involving the fund must not be political decisions. They must be decisions based on what is best for the fund and for beneficiaries of the fund. They must be business decisions. The bill does not even allow the board to determine its own processes and procedures without the consent of the Minister (section 17).

65. The board must not be appointed by the Minister, and the Minister must not have the power to dismiss board members, as stipulated in section 13, because this will interfere with the ability of the board to remain objective in its decision-making. The fund must not effectively be run by the Minister - which is what the bill currently says. The board and not the Minister must have the power to hire and fire the chief executive officer of the fund, since the latter must always be accountable only to the board.

66. The CEO must ensure that decisions of the board, not the Minister, are carried out. The board of the fund must be an executive board and not a nominal board. In other words, the board takes all key decisions relating to the fund and is the ultimate authority on all matters involving its operations. The fund must not be able to take any decisions without the authorisation, knowledge and approval of the board. Section 15(4) says that the board 'may' examine and comment on decisions of the fund. This does not suggest an executive board. We submit that for purposes of decision-making, the board is the fund. A decision by the fund must always be consistent with directives, instructions and guidelines issued by the board. The fund must be run like a business, not a state-owned enterprise.

67. We see in SASSA what a disaster it can be when a Minister has the power to intervene in the decisions of a board and we must avoid repeating that at all costs. There must be an arm's length relationship between the Minister and the fund. Furthermore, the Minister is vested in the provision of health care services and so does not belong on the purchaser side of the purchaser/provider split. BHF submits that there is a need for regulatory supervision of the fund and that this regulatory supervision can best be provided by the

Prudential Authority for financial institutions established in terms of the Financial Services Regulation Act. We discuss this in more detail elsewhere.

68. To further strengthen governance, the NHI fund should be overseen by a regulator that is in a position to deal with specifics relating to the fund such as reserving levels, financial risks of the fund and their management, financial and other reporting standards for the fund and investments by the fund. We recommend that this regulator be the Prudential Authority that resides within the Reserve Bank and was created in terms of the Financial Sector Regulation Act. The Public Finance Management Act, although it applies to the fund, only regulates certain aspects of the fund. There is a gap which we submit must be filled by the Prudential Authority. The latter has the skills and expertise to provide specific oversight of the fund's financial affairs. We made mention of this in our previous comments on the NHI Bill to the Minister of Health. It is crucial that the fund does not find itself in the same circumstances as the Road Accident Fund – bankrupt and looking for bail-outs from the State.

Flow of funding

69. The bill is not clear on how funding will flow to the provider in some cases. At times it speaks of the fund transferring funds and at other times it speaks of paying funds. There is no provision for the payment of funds to provincial health departments and municipalities for services rendered by them. There is no attempt to discriminate between the basic services that provincial and local governments are constitutionally obliged to fund from their equitable share of national revenue and health care services that the fund will be paying for.

70. It seems that the intention of the bill is for the fund to pay money to DHMOs and CUPHCs, which will then further distribute the money to primary health care providers. The problem with this notion is that clinics, hospitals and community health centres in the public sector have no legal or administrative capacity to receive and manage money. They do not have employees who have adequate knowledge of financial management and they themselves do not have juristic personality, which means that they cannot enter into contracts with anyone.

71. BHF does not agree with the proposed system of DHMOs and CUPHCs. It requires that entirely new entities are set up when there are already existing organs of state in the form of provincial governments and municipalities that can organise and provide health care services. Furthermore, CUPHCs have no juristic personality themselves, there is no indication of how they are to be structured and there is no indication that they will have financial management skills. Section 37 says that CUPHCs are to be organised in 'horizontal networks' but who will do the organising, how will they function and what will be the relationship of the elements of the network to each other? Not having juristic personality, how can they contract with the fund? Section 41(3) also says that CUPHCs must contract with accredited primary health care service providers.

72. If CUPHCs do not have juristic personality, then it is legally impossible for them to enter into contracts. What kind of entity are they supposed to be? How will they be managed and who will be in charge of them? The bill is silent on this. BHF does not accept the amended section 31B of the NHA in the schedule to the bill, which states that the fund must 'transfer' funds to the CUPHCs guided by a district health resource allocation formula. This is not acceptable. The fund must *purchase* health care services from providers in terms of a contract and not just 'give' money to CUPHCs based on their budgets. The fund should not be financing CUPHCs. It should be purchasing health care directly from providers themselves. Where the health establishment is owned by a province or municipality, the fund must pay the province or municipality for the relevant health care services. To interpose another body between the funder and the provider blurs the principle of the purchaser/provider split. The fund should be paying providers, not other funders, for health care services rendered to beneficiaries.

73. What will the rules of the CUPHC network be and what happens if a private provider does not want to be a part of such a network because he or she is not getting paid or for some other reason? How will private providers who are rendering primary health care services be paid? Why must there be an intermediary between them and the fund? The bill does not explain the need for this and it is not apparent from the wording of these sections. The provisions in the bill on CUPHCs do not make any sense. Is a CUPHC a purchaser or a provider of health care services? It is a separate entity from the actual providers and its job seems to be more about paying providers than rendering health care services itself. It

seems to us that CUPHCs will just add another unnecessary layer of administrative costs to the health care financing system without adding any value.

74. Why must DHMOs have anything to do with non-personal health services (section 36)? These are the domain of municipalities. In any event the fund should not be paying for non-personal health services. It should only pay for personal health services. Non-personal health services include rubbish removal, disposal of the dead, pollution prevention, environmental health and sanitation. This is the domain of the third sphere of government created by the Constitution. Is the bill trying to create a fourth sphere in the health care sector? Is it the intention to remove certain constitutionally allocated functions from municipalities? On what constitutional basis is this justified? What about the district health councils provided for in section 31 of the NHA? How will their role tie in with those of DHMOs? The NHA requires provincial legislation to provide for the functioning of district health councils. It also states that a district health council must ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established. DHMOs are superfluous and add another unnecessary layer of complexity that will divert funds that should be available for health care costs to administrative costs for the fund. It is not necessary to have district health councils, municipalities, provinces and DHMOs.

75. Section 35 says that the fund must 'transfer' funds directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget and DRGs. BHF does not agree with this. The fund must pay for services rendered in terms of a contract between itself and another entity with juristic personality. It is not the role of the fund to finance these different health establishments. They must get money for infrastructure, capital expenditure and equipment costs from the province's equitable share. The fund must reimburse them only for health care services rendered to beneficiaries. Furthermore these hospitals are only public sector hospitals. What about private hospitals? There should be an even playing field for public and private providers of health care services and all payments made by the fund must be on the basis of contracts. The provincial governments, not the fund, must finance public health establishments. Section 35 violates the principle of the purchaser/provider split in requiring the fund to transfer money to public hospitals.

76. BHF notes with concern that the management of public hospitals is already poor and that these hospitals are highly unlikely to be able to manage tranches of money that are simply transferred by the fund efficiently and effectively. Who at these hospitals is going to manage the money? The bill is totally impractical in assuming that the fund can just transfer money to public hospitals. These hospitals do not employ anyone - the provincial departments of health employ everyone that works in these hospitals. The provincial departments of health own and manage these hospitals. Why then should payment be made to the hospital as opposed to the provincial departments of health? Money paid directly to public hospitals may disappear because it is stolen, mismanaged or wasted. Individual hospitals do not always have the skills necessary to manage money.

77. The chapter in the bill on financial matters is missing some important provisions. It contains no requirements for financial management of the fund, financial planning or budgeting or whether the fund can give loans or not and if so, to whom. It contains no restrictions on the administrative costs of the fund, how money owing to the fund must be recovered, whether the fund can borrow money and on what basis, the levels of reserves to be held by the fund and how the fund must invest money, among others.

78. There must be strict provisions in this section for maintaining the purchaser/provider split. For instance the fund must not be allowed to buy shares in private hospitals, pharmaceutical companies, health technology companies or other private companies. It must not be allowed to borrow money from entities in the health sector. The fund must not be allowed to own or run public or private establishments or sponsor them in any way. The fund must not be allowed to employ health care professionals to provide services. The role of the fund purely as a purchaser of services and health goods must be entrenched in this section. The fund must not finance health service delivery programmes or run such programmes. It must only pay for personal services and health goods provided to beneficiaries. The fund must not be allowed to establish any new public or private entities. The fund must not be allowed to enter into joint ventures with private companies nor must it be able to partner with NGOs that deliver health care services. The fund must not be allowed to make gifts or donations to persons or entities operating in the health sector. These matters are not provided for in the Public Finance Management Act. Therefore they should be covered in the bill.

79. The fund should be given the right to recover money that it has lost through fraud, waste and abuse or professional misconduct directly from the responsible health care providers or suppliers, notwithstanding anything to the contrary contained in any other law. It should be allowed to reverse payments that it has made in error or to which a provider is not entitled. The fund must also have the power to monitor the expenditure of health establishments contracted to it and prevent and recover fruitless and wasteful expenditure by them and from them. It should also have the power to investigate financial misconduct by entities with which it contracts. The fund must not be allowed to borrow money to cover its liabilities to beneficiaries. It must always have the funds necessary to cover its own liabilities. Lending institutions must not indirectly become responsible for the sustainability of the fund.

The Role of Provincial and Local Government

80. The bill largely ignores the role of provincial and local governments in the delivery of health care services. We have already alluded to this as a problem. Throughout the bill, the focus is on public hospitals and clinics and distinct entities on the provider side of the equation. This is completely impractical and takes no account of the fact that public hospitals and clinics have no legal personality of their own. As such they are unable to contract, unable to sue and be sued in their own names, unable to employ staff and unable to own moveable or immoveable property. They are in fact owned by provincial and local governments. Therefore provincial governments and municipalities are the true providers of public health care services. They are organs of state as defined in the Constitution, they employ the people working in public hospitals and clinics, they manage the finances and other resources of these institutions and are accountable for them in terms of the Public Finance Management Act and the Municipal Finance Management Act. Yet the bill seems to be denying them their key role as providers of public health services.

81. Instead the bill seems to be trying to create a fourth sphere of government in the form of DHMOs and CUPHCs to replace provincial departments of health and municipalities. BHF believes that this is not only unconstitutional but unnecessary. Rather than replacing provincial departments of health, they should be strengthened in respect of their management capacity and power to employ people with the necessary skills and qualifications to effectively run public health establishments. Amendments to the NHA could achieve this. Provincial and local government has a constitutional duty to provide

basic services and BHF believes that this includes basic health services - especially in the case of provincial governments. They must fund these basic services through their equitable share of national revenue (section 214 of the Constitution). This is a constitutional requirement. It represents a predicament as funding for such services therefore cannot take place through the NHI fund without constitutional amendments.

82. There will be many people in South Africa who are not beneficiaries of the fund for various reasons. Some of these reasons are that they are not citizens or permanent residents, do not have South African identity documents, are refugees or illegal immigrants, contract workers or tourists. The fund will only be financing the health care of beneficiaries. The provinces and municipalities that provide health care services will have to fund the basic health care needs of non-beneficiaries. For this they will need money. That money will have to come from the national revenue fund. They will still be materially involved in health service delivery to both users and non-beneficiaries. Why then is it necessary to bypass them under NHI and pay money directly to public health establishments?

83. Provincial governments and municipalities are obliged by the Constitution to engage in co-operative government with the national sphere. The Constitution envisages the three spheres of government working as a whole to provide for the needs of the people of South Africa. Upholding effective government and sound intergovernmental relations in and among all spheres is vital for effective and successful democratic government throughout the nation. It should be appreciated that all spheres have an essential role to fulfil in the establishment of a democratic culture and in sustaining the overall legitimacy of the constitutional system.[13] Why is the bill trying to bypass provincial and local government? There is no reasonable explanation for this and it is inconsistent with the system of government set out in the Constitution.

84. Health services are an area of national and provincial legislative competence in terms of schedule 4 of the Constitution. National government does not have exclusive powers to legislate on health care. BHF submits that it appears that the intention of the NHI Bill is to divert resources for health care away from provincial departments of health and municipalities and that this approach is fundamentally flawed. It undermines the role of

[13] Malherbe R 'The unconstitutionality of unfunded mandates imposed by one sphere of government on another' 2002 TSAR 541

the provinces in the delivery of health care services and is inconsistent with the notion of three spheres of government in the Constitution. Section 41 of the Constitution states that the three spheres of government must exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere. The NHI Bill allows the national government to encroach on the functional and institutional integrity of provincial departments of health and municipalities. Where is the constitutional justification for this? In section 125(3) of the Constitution it clearly states that the national government, by legislative and other measures, must assist provinces to develop the administrative capacity required for the effective exercise of their powers and performance of their functions. The national government should not be looking to do away with the provinces' exercise of the powers and performance of their functions.

Purchaser/Provider Split

85. The White Paper on NHI recognises and endorses the principle of the purchaser/provider split to improve accountability and the rational allocation of resources. BHF believes that it is essential to ensure that all provisions of the bill support this principle. There must be a distinct dividing line between entities that are responsible for health service delivery or the supply of health goods on the one hand and the fund on the other. This division is essential for maintaining proper control of health care financing.

86. Health care must be provided based on formal contracts between the fund and health service providers. For this reason, we are opposed to the notion that the fund 'transfers' money to any health care provider, public or private. The fund must always play the role of a purchaser in any transaction for health care goods and services. The provider should always play the role of the seller. The fund, as purchaser, must not *finance* the seller. Rather it *pays* the provider (seller) for services. The fund must not become simply an agent for the division of revenue. It must use proper reimbursement mechanisms with appropriate contractual conditions to pay providers.

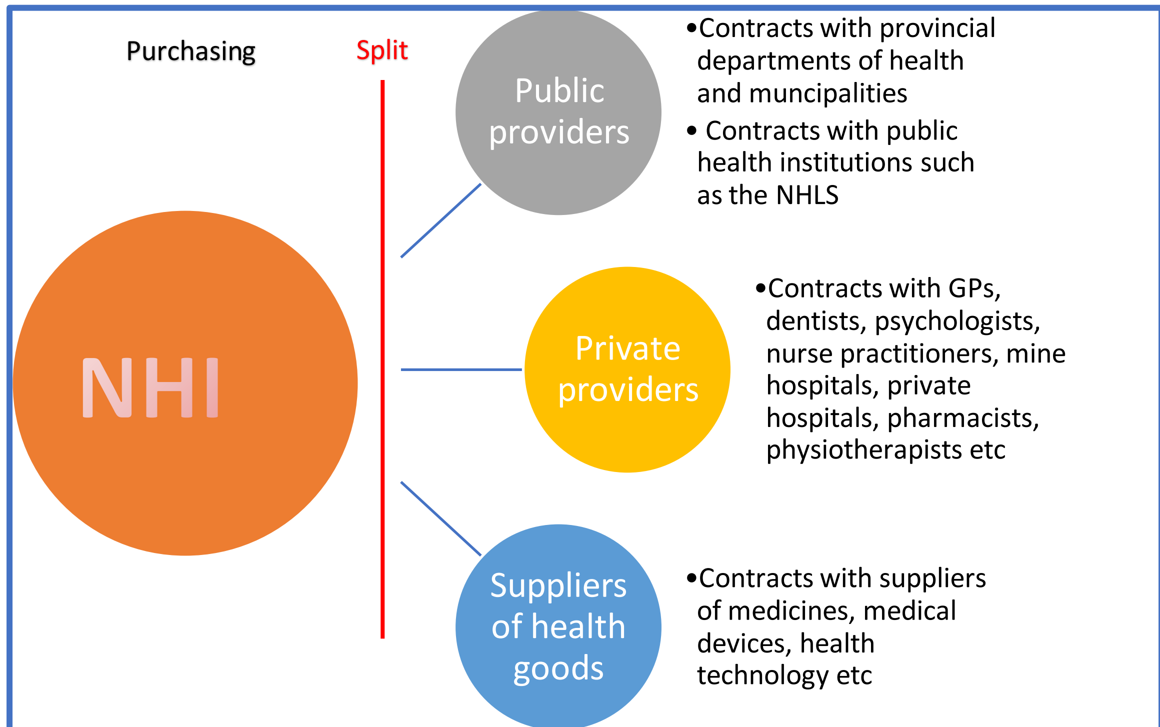
87. One of the main aims of the purchaser/provider split is to create competition between providers. Competition and other incentive structures built into the contractual relationship are believed to lead to improvements in service delivery, such as improved cost

containment, greater efficiency, organisational flexibility, better quality and improved responsiveness of services to patient needs.

88. While a single definition for purchaser/provider split is difficult to find, the concept subsumes certain basic assumptions, the relevance of which varies across the countries that have implemented this split in their service delivery. In a purchaser/provider split public third-party payers are kept organisationally separate from service providers and the operations of providers are managed by contracts. A general assumption about the purchaser/provider split is that the purchaser is able to articulate the needs and wishes of the population and make plans for service delivery based on this knowledge. In addition, it is assumed that a separate purchaser agency is able to be more explicit about the costs and the quality of the services and also to better match political decision-making and service system priorities with the allocation of the resources. The purchaser/provider split also allows competition between providers, which is often believed to yield benefits such as efficiency, cost-effectiveness and improved quality.[14]

89. The notion of a purchaser/provider split requires formal procurement processes between the funding side of the equation and the provider side. It requires financial planning by both the funder and providers. Therefore it creates a more controlled environment on both sides of the equation. The language of the bill must reflect and support the principle of the purchaser/provider split. Providers must not be required to fund health care services purchased by the fund. Providers must also be independent, and responsible and accountable for their own financial management. The fund must not be responsible for providers within the system and must not be allowed to provide health care services and/or supply goods itself. Its role must be a financial role and not a medical one. If the Minister of Health is going to provide health care services through the national Department of Health, then the Minister and department must not play a role on the financing side of the equation.

14 Tynkkynen L, Keskimaki I, Lehto J ‘Purchaser-provider splits in health care - The case of Finland https://www.sciencedirect.com/science/article/pii/S0168851013001371



Detailed Commentary on the Sections of the Bill

90. The term 'user' should be deleted and the word 'beneficiary' inserted in the definitions section of the bill as follows:

    'Beneficiary' means a person enrolled with the fund in terms of section 5 and who is entitled to receive benefits from it.

91. A 'child' should be defined simply as 'a person defined as such in section 28(3) of the Constitution'. The words 'means a person under the age of 18 years' are unnecessary.

92. The term 'complementary cover' in section 1 should be deleted.

93. The definition of 'comprehensive health care services' in section 1 is so vague that it is meaningless. What if the health care services are not 'managed' as envisaged in the definition? Then the health care services in question do not satisfy the definition. The health care services must be managed by whom? The provinces? The national Department of Health? The NHI fund? It is recommended that the definition of 'comprehensive health

care services' be deleted in section 1 and the word 'comprehensive' in relation to health care services be deleted wherever it occurs throughout the bill.

94. The definition of 'emergency medical services' is so broad that it includes all primary health care, regardless of urgency. It says that it 'means services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment…'. This includes all non-chronic treatment in government clinics, private GP practices, and physiotherapy practices, among others. Not all acute care is an emergency. Emergency medical services are those that are needed in a hurry. Ideally the definition should read as follows:

    '*Emergency medical services'* means the health care services that are immediately necessary to prevent permanent impairment of bodily function or imminent death, and include the urgent, specialised transportation of a beneficiary by ambulance or other specially equipped emergency vehicle to a public or private health establishment.'

95. In the definition of 'formulary', the words 'and its composition' should be deleted because they are meaningless.

96. The term 'health care services' should not include paragraph (d) in the definition. It must be deleted. Health care services should not be defined in terms of the entity that delivers them. They should be defined with reference to the relevant sections of the Constitution and what they essentially are, regardless of where or by whom the service is rendered. Municipal health care services are not defined in the bill. In terms of the NHA, municipal health care services are non-personal health services. This Act defines them as:

    (a) water quality monitoring;
    (b) food control;
    (c) waste management;
    (d) health surveillance of premises;
    (e) surveillance and prevention of communicable diseases, excluding immunisations;
    (f) vector control;
    (g) environmental pollution control;
    (h) disposal of the dead; and
    (i) chemical safety.

97. The *NHI fund should not be paying for non-personal health services*. Municipalities levy rates and taxes to fund their mandate. The NHI Bill cannot, constitutionally speaking, restrict the power of municipalities to raise rates and taxes with which to pay for municipal health services; neither should the NHI fund usurp the role of municipalities in funding and providing non-personal health services. In terms of section 156(1) of the Constitution, municipalities have executive authority in respect of, and the right to administer:

    (a) the local government matters listed in part B of schedule 4 and part B of schedule 5; and
    (b) any other matter assigned to it by national or provincial legislation.

98. Municipal health services appear under part B of schedule 4 of the Constitution whereas 'health services' appear on part A of schedule 4. The Constitution therefore distinguishes between health services on the one hand and municipal health services on the other. The Constitution identifies municipal health services as a municipal function. Section 84 of the Municipal Structures Act No 117 of 1998 gives district municipalities functions and powers regarding municipal health services. The NHI Bill does not amend the Municipal Structures Act.

99. The definitions 'health goods' and 'health-related products' in section 1 largely overlap. It is difficult to see why both definitions are necessary. Health goods include medical devices and supplies, medical equipment and health technology while a health-related product effectively also includes all of these except for medical devices. Medicines are excluded from both definitions unless the term 'supplies' in the definition of health goods is intended to include medicines. They are not explicitly mentioned in the definition of 'health goods'. This is likely to cause confusion. The phrases 'health goods' and 'health- related products' are essentially definitions without distinction, which makes for confusion when reading the bill. Why not just include mechanical, chemical, electrical and other commodities described as health-related products in the definition of health goods? How is 'health research' in the definition of 'health goods' consumed? Research is not a material object. It should be omitted from the definition.

100. It is recommended that the definition of health goods be replaced with the following: *'Health goods'* include medical equipment, medicines, medical devices, and supplies or health technology intended for use or consumption by, application to, or for the promotion,

preservation, diagnosis or improvement of the health status of, a human being .' The definition of health-related products should be deleted.

101. It is recommended that the term 'medical device', as used in the Medicines and Related Substances Act (No. 101 of 1965), be included in the definition section of the NHI Bill. This can be done simply by stating that the terms 'medicine' and 'medical device' have the meanings ascribed to them in the Act. This was suggested in BHF's previous comments on the 2018 bill, to no effect.

102. It is recommended that a definition of 'Protection of Personal Information Act (POPI)' be inserted into section 1 because this Act needs to be referred to in the bill. The POPI Act is even more important than the Promotion of Access to Information Act (PAIA) as it is critical with regard to NHI data processing. POPI has a definition of 'personal information' that is just as wide, if not wider, than that in PAIA. POPI is, however, more pertinent to data processing than PAIA. Data processing will constitute a major component of the work of the NHI fund whereas PAIA is just about access to records.

103. The definition of 'primary health care' is defective because of its use of vague terms that have no meaning in law. What does 'main' mean in relation to health problems? How does one determine whether a health problem is a 'main' one or not? Also, are emergency medical services included in the definition of 'primary health care'? The definition is not clear because it refers to promotive, preventive, curative and rehabilitative services but not emergency medical services. The latter has its own definition which suggests that it is separate from primary health care as far as the bill is concerned. What health problems in the community are excluded from the definition of primary health care by the use of the word 'main'?

104. The definition of 'provider payment' is also flawed. If a provider is not paid in a way that creates appropriate incentives for efficiency, then this payment does not satisfy the definition. In legal definitions one must define the 'what', not the 'how'. If a payment is not part of a uniform reimbursement strategy then is it not a payment under the NHI Bill. What is meant by a 'uniform' reimbursement strategy? Does it mean that every provider must be paid the same even if various providers render various kinds of services that might require differing reimbursement strategies? For example, one may wish to

pay a capitation fee to GPs but use DRGs to pay hospitals. The word 'reimbursement' is also inappropriate here because it suggests that only the provider's costs for providing the service will be paid. One 'reimburses' expenses that someone else has incurred out of their own pocket. Private providers need to be paid more than just the costs they have incurred in rendering the health services. They have to be able to earn a living or make a profit because without making a profit they will not survive. It is recommended that the definition of 'provider payment' in section 1 be altered to read:

'*Provider payment'* means the payment of money to health care service providers from whom the fund is purchasing health care services on behalf of beneficiaries.'

105. The definition of *'referral'* should be amended to read: 'means the directing of a beneficiary to an appropriate health establishment suitable for his or her health needs'.

106. The definition of *'social solidarity'* should be deleted because it is a policy term and not a legal one. It has no meaning in law.

107. The definition of *'strategic purchasing'* is also unnecessarily vague and inappropriate. What is meant by 'active' purchasing in legal terms? It means nothing. The 'pooling of funds' issue has already been addressed in the definition of 'social solidarity'.'. Why must it also be included in the definition of 'strategic purchasing'? The act of purchasing has nothing to do with the act of pooling funds. They are two separate concepts. The term 'strategic purchasing' comes from the literature on UHC. It is not a legal term but a policy term. If one were to accurately define ' strategic purchasing' it would be 'the purchasing of health care services on behalf of beneficiaries in accordance with a strategy intended to ensure the optimum utilisation of health care resources by securing the availability of quality health care services at the most reasonable price from health care service providers'. Currently the definition of 'strategic purchasing' is virtually meaningless. Furthermore, the NHI fund will not be purchasing health care services on behalf of the 'population'. It will only be purchasing health care services on behalf of beneficiaries.

108. BHF is of the view that the words 'accredited and' in section 2(c) are unnecessary and likely to cause confusion. A provider must be contracted before the fund can purchase heath care services from him. The fund should only contract with health care providers

and health establishments if they meet the fund's contracting criteria. Accreditation should not be a separate process from the contracting process. What is the use of being accredited if one is not contracted? During the contracting process the fund must ascertain whether the provider meets the fund's contracting criteria. If he or she does not, then there should be no contract. There is no need for a separate accreditation process. It is likely to be an extremely costly and logistically time-consuming task, given the number of health care providers in South Africa, which we have indicated based on our PCNS database further on in this document. If the OHSC certifies a provider then the fund should be free to choose whether or not to contract with that provider based on the fund's own contracting criteria.

109. It should be stated in section 3 that the Act also applies to health care providers, not just public and private health establishments. Health establishments are often merely locations where health care services are rendered.

110. It should further be stated in section 3 that the Act also applies to beneficiaries.

111. BHF does not accept that the fund must purchase health care services 'in consultation with' the Minister as stated in section 4(1). The Minister is one person. He does not have the expertise, knowledge or skill to make correct purchasing decisions or to veto purchasing decisions. The fund must not be hobbled by the Minister in exercising its purchasing power. The Minister should also not be referring purchasing decisions by the fund for input by officials in the national Department of Health. The NHI fund must operate independently and be able to make purchasing decisions based on the advice of its own experts.

112. We have seen how the Minister of Social Development improperly interfered with contracting by SASSA. The latter was hobbled by the Minister to such an extent that this threatened the stability of the entire social security system. It also opens NHI up to corruption because one individual, the Minister of Health, can intervene in purchasing decisions by the fund. The Minister of Social Development has the power to approve of and influence contracts entered into by SASSA and has been accused of wanting 'to run SASSA like her own shop' by former SASSA chief executive, Thokozani Magwaza, who said she disturbed the smooth running of the organisation. It emerged from the

constitutional inquiry into whether Minister Bathabile Dlamini should be held personally liable for the social grants fiasco that SASSA's executive committee was marginalized by Dlamini. *We do not want a repeat of this situation in NHI.*

113. The fund must also not be hobbled by the Benefits Advisory Committee. The latter is only an 'advisory' committee and must therefore not be allowed to 'determine' what health care services the fund must purchase. The board of the fund must be accountable for purchasing decisions made by the fund. It cannot be held accountable if these decisions are dictated by the Minister and the Benefits Advisory Committee. The board, not the Minister and not an advisory committee, must be responsible for all aspects of corporate governance of the fund. Even if the Benefits Advisory Committee sits within the fund, it is not the board of the fund and does not contain board members. It is the Minister who decides on the composition of the Benefits Advisory Committee in terms of section 25 of the Bill. These people are therefore not accountable to the board of the fund. Once again this gives the Minister of Health too much power over the operations of the fund. The role of the Minister of Health is not that of a health funding expert.

114. It is recommended that in order to avoid ministerial intervention in the operations of the fund, it should be accountable to Parliament and the role of the Minister of Health should be expressly set out in such a manner that he does not have the power to decide on with whom, how and on what basis the fund contracts or conducts its business. The Minister of Health, as a provider of health care services, has a vested interest in the supply side of the health equation. He is not neutral in the purchaser/provider split because the national Department of Health is to provide health care services through central hospitals and the like. The fund is a purchaser of services and so it is not appropriate for providers to have a material say in how it is run or the nature of the services it must provide.

115. Section 4(3) entitles asylum seekers and illegal foreigners to emergency medical services, but these services are currently too widely defined and include all primary health care services as explained previously. Emergency medical services should only include those urgent services that are required in an emergency situation to save a life or prevent permanent disability.

116. Section 4(4) is badly worded and thus potentially unconstitutional. It effectively says that only registered beneficiaries may obtain health care services from a provider 'accredited' by the fund. What about people who are not beneficiaries, or who are not registered as such, and who seek services from providers accredited by the fund? This section implies that if a provider is just accredited by the fund, he doesn't even have to be contracted to the fund, he cannot provide health care services to non-beneficiaries or persons not registered as users at their own expense. This is totally unacceptable and *will discourage private providers* from being accredited by the fund.

117. A provider can be accredited by the fund but not contracted to the fund according to the wording of the bill. BHF submits that providers who are contracted by the fund and providers who are only accredited but not contracted must also be allowed to provide services to non-beneficiaries and non-registered beneficiaries. This is an example of why BHF argues that provider accreditation and contracting should not be two separate processes. There is too much room for confusion. Neither accreditation by, nor a contract with, the fund should ever preclude a private provider from serving private patients at their own expense. Consequently section 4(4) should be amended to read as follows:

> 'A person who is eligible to be a beneficiary in terms of this section, and who seeks health care services from a contracted health care service provider, must be registered as a beneficiary as provided for in section 5 and must present proof of such registration to the contracted health care service provider in order to secure the health care service benefits to which he or she is entitled in terms of this Act'.

118. Sections 5(1) and 5(2) and 5(4)(b) once again use the word 'accredited' as opposed to 'contracted'. What is the point of a beneficiary registering with a health care provider who, although accredited, is not contracted by the fund to provide services? He will not be able to obtain health service benefits from a provider who is only accredited by the fund. Section 2 says the fund must purchase services from 'accredited *and* contracted' health care service providers. In other words, they must be both accredited and contracted. They cannot just be one or the other.

119. Section 5(1) would make more sense if section 2 just said 'contracted' because only a provider who is contracted to the fund is going to get paid for rendering health care services to a beneficiary. As it is, there is a likelihood of confusion and misinterpretation

of what the bill intends. It is also unnecessary to specify a health care service provider *or health establishment* (see sections 5(1), 5(2)(a) and 5(4)(b)). The words 'health establishment' should be deleted. A health establishment is a *location* at which health care services are provided. The NHA defines a 'health establishment' as 'the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services'. A place does not provide health care services. A person does. That person can be a natural person or a juristic person.

120. Section 5(5) requires the production of an identity card and an original birth certificate. Why must a person produce an original birth certificate if he or she has an identity card? This is creating unnecessary obstacles to registration as a beneficiary. For permanent residents and even South African citizens who were not born in South Africa, it can be difficult if not impossible to obtain an original birth certificate. Even for citizens who were born in South Africa getting an *original* birth certificate out of the Department of Home Affairs can be a costly, lengthy and frustrating experience. The Department of Home Affairs will be swamped with requests for original birth certificates since every beneficiary will have to produce one in order to register.

121. What happens to people who have lost their birth certificates or had their identity cards lost or stolen? According to the bill the 'identity card' must be as defined in the Identification Act, 1997. This is a highly specific form of identification that does not necessarily include the green identity document that the majority of South African still use. For one thing, that document is a booklet and not a card. It also does not contain fingerprints as set out in section 14 of the Identification Act. It is therefore recommended that section 5(5) read as follows:

'When applying for registration as a beneficiary, a person concerned must provide:

(a) satisfactory proof of his or her identity,

(b) his or her biometrics, including fingerprints and photographs,

(c) proof of habitual place of residence,

(d) where applicable, proof of refugee status

and such other information as may be prescribed.'

122. BHF submits that the fund, and not the health care provider, must register and maintain a register of all beneficiaries. Otherwise there is the possibility of multiple registrations by the same person, duplication of registrations and different information in respect of the same beneficiary. The beneficiary register must be central and kept by the fund. The content and composition of the register and provisions relating to its confidentiality should be set out in regulations under the NHI Act.

123. Section 5(7) makes no sense. It requires *unaccredited* health establishments, whose particulars are published by the Minister in the gazette, to maintain a register of *all* beneficiaries on behalf of the fund. This means that the Minister of Health can require every private hospital, regardless of whether or not it is accredited by the fund, to maintain a register of every single beneficiary of the fund. At whose expense must this be done? Why must *any* health establishment maintain a register of *all* beneficiaries of the fund let alone multiple health establishments? The fund alone must keep a register of *all* beneficiaries. Even if it were practical, which it is not, this is just going to create the possibility of multiple beneficiary databases that do not match each other and will cause confusion and misunderstandings. These misunderstandings are likely to result in a loss of access for some beneficiaries. The fund must maintain a central registry against which individual health establishments can verify their own beneficiary records. The fund can have an updating system whereby health establishments can submit new beneficiary data for incorporation into the single central database.

124. Section 6(c) once again refers to accredited health care providers as opposed to 'accredited and contracted' or just 'contracted'. It also once again refers to providers as well as health establishments. Health establishments are locations, not persons. They do not provide health care unless they have juristic personality, in which case they are health care providers in addition to being health establishments. The vast majority of public health establishments do not have juristic personality and so are merely locations at which health care services are provided by the provinces or by municipalities. The wording 'within the State's available and appropriated resources' is inappropriate. It is irrelevant how the State obtains its resources. They are its resources, whether appropriated or not. Secondly, the NHI fund is not the State. The State has resources that are not available to the NHI fund because the State's resources are not the resources of the NHI fund. This section should be amended to read as follows-:

'…a beneficiary of health care services purchased by the fund is entitled, within the fund's available resources…'

Section 6(c) is totally unnecessary because it only awards a right that is already granted under PAIA. Furthermore, there are other laws applicable in the context of a beneficiary's right to access to information or records relating to his or her health. Section 6 and section 10 of the NHA are examples, as is section 5 of PAIA. Section 6(c) should therefore be deleted.

125. Section 6(f) is too vague. What is a 'reasonable' time period? The word 'reasonable' alone conveys no sense of how such a time period must be determined. It is recommended that the words 'determined with reference to the nature of his or her need for such health care services, the urgency of such need and the nature of the health care services required for his or her specific health condition' must be added after the words 'within a reasonable time period'. What are the beneficiary's rights if he or she does not have access to such health care within a reasonable time period? He or she should also have the right to obtain the services he or she needs from other sources and by other means, even if they are covered by the NHI.

126. Section 6(h) is unnecessary repetition of what is already contained in much more detail in sections 6, 7 and 8 of the NHA and should be deleted.

127. Section 6(m) is poorly drafted. POPI is only one aspect of the law on privacy and confidentiality and is predominantly about data *processing*. The NHA in sections 14, 15-, 16 and 17 also provides for confidentiality and privacy as does the Constitution and there is a well-developed common law of privacy in South Africa too. It is recommended that section 6(m) be amended to read as follows:

'to the full protection of his or her rights to confidentiality and privacy accorded to him or her by the law, provided that his or her personal information may be utilised by the fund for any lawful purpose necessary for the fund's fulfilment of its functions or the exercise of its powers under this Act.'

128. Section 6(o) must be amended to read 'to purchase health care services through a medical scheme registered in terms of the Medical Schemes Act or at his or her own expense, or through any other lawful form of funding for health care services available to him or her in circumstances where he or she is unable or unwilling to obtain health care services through the fund'. The right of a beneficiary to all forms of access to services must not be restricted. NHI is just one form of access. It must not be unlawful for a beneficiary to purchase services, whether or not they are covered by the fund. Such a provision is unconstitutional for the reasons already explained.

129. Section 7(1) once again states that the fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, for the benefit of beneficiaries. This is a repetition of section 4(1) and unnecessary. Furthermore, BHF does not agree that the Minister can veto purchasing decisions of the board of the fund, or that the Benefits Advisory Committee can dictate to the fund what health care services to purchase. BHF has already given reasons for this in the discussion of section 4(1) above. If the fund cannot afford to purchase all of the health care services determined by the Benefits Advisory Committee this will mean the fund has an unfunded liability. The words 'in consultation with the Minister' should be deleted and the word 'determined' should be changed to 'recommended'.

130. Section 7(2)(c) says that where a health care services provider is not able to provide the necessary services, the provider in question must 'transfer' the beneficiary to another one who can. This is inappropriate. The health care provider should 'refer' the beneficiary to another health care provider. It should not be the responsibility of the health care provider to transport the beneficiary to another health care provider or health establishment. The vast majority of beneficiaries will be ambulatory. Transport to another health provider or health establishment is only necessary where the patient is so ill or injured that he or she requires specialised medical transport that can keep him alive on the journey. Not all health care providers provide such transport; neither should they be forced to do so.

131. Section 7(2)(f) belongs in the NHA and not the NHI Bill. It should be deleted from the latter. What is meant by 'semi-autonomous' in section 7(2)(f)? This has no meaning in law.

132. Section 7(4)(c) refers to a 'complementary list'. There is no indication in the bill as to what this means or what the list must contain. Who must draw up this 'complementary list' and why is it the Minister who must approve it? What is its status vis à vis the formulary? The latter is referred to in section 38(4). It requires the Office of Health Products Procurement to 'support' the Benefits Advisory Committee in the development and maintenance of the formulary. Why should the formulary simply not be amended from time to time so that there is no need for a 'complementary list'?

133. Section 8(1) once again refers to an 'accredited' health care provider as opposed to 'accredited and contracted'. It is also an unnecessary repetition of section 6(a). Section 8(1) should be deleted as it adds nothing to section 6(a).

134. Section 8(2) must be amended to read –

'A person or beneficiary, as the case may be, may pay for health care services rendered directly, through a medical scheme or through any other resource available to him or her, if that person or beneficiary…'

The current wording says he 'must' pay. It should be altered to read 'may'. The person or beneficiary must have discretion whether or not to use a medical scheme. We note that there is no such thing as a 'medical insurance scheme'. There are medical schemes and then there are insurance policies. By law insurance companies are not allowed to do the business of a medical scheme. This section of the NHI Bill ignores the demarcation regulations made in terms of the Long Term and Short Term Insurance Acts, which prohibit health insurance by insurance companies. The word 'or' should be inserted after 8(2)(a),(b),(c) and (d) to indicate that each of the circumstances envisaged is distinct from the others.

A further sub-section(e) should be added to section 8(2)as follows:

(e) seeks health care services not covered by the fund.

135. It is recommended that section 9 be amended to clearly state that the fund has juristic personality and can enter into contracts, conduct its affairs and sue and be sued in its

own name rather than using the word 'autonomous' which is too vague and open to interpretation. Section 9 should be amended to read:

'The National Health Insurance fund is hereby established as a juristic person, capable of entering into contracts, suing and being sued and conducting its own affairs in its own name and shall be an entity referred to in Schedule 3A of the Public Finance Management Act.'

136. It is recommended that section 10(a) be amended to read as follows:

'(a) take all reasonably necessary steps to achieve the objective of this Act as set out in section 2'.

Section 2 does not set out the objectives of the fund; it sets out the objectives of the Act. The phrase 'universal health coverage' is meaningless in law. How does one determine when it has been achieved? What are the indicators? What is meant by 'universal' in this context? The fund will only cover beneficiaries. It will never cover everyone. Not all people will be beneficiaries. Some will not be eligible for NHI benefits.

137. It is recommended that section 10(b) be amended to read:

'purchase and procure from its resources health care services, medicines, and health goods from health care service providers and product suppliers that are contracted by the fund.' It is unnecessary to require the fund to 'pool' the resources. The fund is the pool. The term 'actively' purchase means nothing in law.

138. Section 10(1)(c) is contradicted by section 4(1) which says the fund must purchase health care services 'determined' by the Benefits Advisory Committee. Section 10(1)(c) says that the fund must purchase health care services 'as advised' by the Benefits Advisory Committee. BHF submitted that section 4(1) be changed so that its wording is consistent with section 10(1)(c).

139. The word 'accredited' in section 10(1)(d) should be deleted as per previous submissions on the subject of accreditation of providers by the fund.

140. What does 'equity' mean in section 10(1)(e)? Equity in what? How does it relate to 'timely reimbursement'-? It is submitted that section 10(1)(e) should be altered to read:

'(e) timeously pay health care providers for health care services received by beneficiaries in order to ensure that such services are not unfunded and that health care providers are able to render the services in a timely manner'.

141. BHF recommends that a further paragraph is added to section 10(1) after paragraph (n) as follows:

'(o) establish and maintain the information systems and databases necessary to enable it to adequately perform its functions'.

The rest of the sub-paragraphs can then be renumbered accordingly.

142. BHF submits that it is the task of the national Department of Health, and not the fund, to maintain a national database on the demographic and epidemiological profile of the population because not everyone will be covered by NHI. Therefore section 10(1)(q) should be deleted. The NHA in section 74 states that;

'The national department must facilitate and coordinate the establishment, implementation and maintenance by provincial departments, district health councils, municipalities and the private health sector of health information systems at national, provincial and local levels in order to create a comprehensive national health information system.'

Also, in the schedule of the NHI Bill, section 21 of the NHA is amended to read 'develop and maintain a national health information system', clearly making this a responsibility of the national Department of Health.

143. Section 10(3) turns health policy into law. This is constitutionally unacceptable because policy is not law. Section 10(3) should be amended to read:

'The fund must take national health policy into account when performing its functions.'

144. It is completely unnecessary to stipulate in section 11(1)(a) that the fund must comply with all applicable labour laws. The fund must comply with all applicable law. Labour law does not have to be reinforced by the NHI Bill. It is already law and so the fund must comply just like any other employer.

145. Section 10(1)(f) apparently allows the NHI fund to insure against its liability to pay for health care services. This is not acceptable or practical. Government self-insures because there is no insurance company big enough to ensure government. Furthermore, the fund

must not be able to transfer its liability for funding health care services onto private insurance companies. This section must be deleted.

146. BHF is opposed to the statement in section 11(1)(i)(vii) that the design of the health care service benefits to be purchased by the fund must be done 'in consultation with the Minister'. The Minister should not be a benefit design expert. This may create an opportunity for political meddling. The phrase 'in consultation with the Minister' must be deleted.

147. The word 'prescribed' must be deleted from section 11(1)(m). The fund must be free to determine the terms of the contracts it enters into. These terms must not be contained in regulations.

148. Section 11(2) should be deleted. It is a repetition of section 11(1)(m) and states the obvious – that the fund must comply with the Act. Section 11(2) should contain only the following provision:

'The fund must negotiate and enter into contracts that:

(a) take into account the best interests of beneficiaries;

(b) reflect prices that are fair and reasonable and that take into account the quality of the health care services and health goods to be provided;

(c) are consistent with the purpose of the Act as set out in section 2.'

The 'lowest possible prices' can mean that quality is compromised. The lowest possible price is not always the best price. Providers have to be able to make a living. They too have to be sustainable. They are the other side of the health care equation and the fund should not put them into bankruptcy.

149. The board should be accountable to Parliament and not the Minister as provided in section 12. There needs to be three-way reporting and accountability - to Parliament, to the Minister in terms of the PFMA and to the Prudential Authority for financial oversight.

150. Section 13 of the Act says the board should be appointed by the Minister. BHF disagrees. This opens the path for corruption and political influence with the board. The board should be appointed by Parliament. Parliament, not the Minister, should also be able to remove

a board member from office. Parliament should be able to dissolve the board – not the Minister.

151. The Minister should not be allowed to appoint a chairperson of the board as stated in section 14(1). The board members should elect a Chairperson and deputy Chairperson from among themselves. The appointment of the Chairperson should not be a political decision. The Minister must not be able to influence the structure and composition of the board.

152. Section 15(1) is an unnecessary repetition of section 12. The words 'and is accountable to the Minister' should be deleted.

153. Section 15(3) should be rewritten completely. The board should not be advising the Minister on its own internal operational issues such as collective bargaining and its budget. There must be no political interference with the board. The Minister should receive reports from the board on a periodic basis, which he should table in Cabinet. The board should not be obliged to inform the Minister of every detail concerning its functioning. Section 15(3) should be amended to read as follows:

'(3) (a) The board must furnish the Minister with quarterly reports on the progress of the fund in fulfilling its mandate, which the Minister must table in Cabinet;

(b) The board may advise the Minister on any matter that it deems necessary, including but not limited to:

(i) national health policy;
(ii) the implementation of this Act and other relevant legislation;
(iii) the national health system;
(iv) health care services purchased by the fund;
(v) financial matters concerning the fund.

154. Section 15(4)(d) must be deleted. The board does not give advice to the CEO. It instructs him. The Minister must not be able to intervene in the instructions given by the board to the CEO. The CEO must report to and be subordinate to the board. The Minister is not the CEO's boss, the board is.

155. It is recommended that section 16(2) should read as follows:

'A member of the board must not:

(a) be a director, owner, partner, employee, agent or officer of a company or other organisation with which the fund has contracted or may contract;
(b) be a government employee or an employee of the fund;
(c) attend, participate in, vote at, or influence the proceedings of, a meeting of the board or of a board committee if that member has an interest, including a financial interest, which precludes him or her from acting in a fair, unbiased and proper manner.'

156. It is recommended that the word 'confidential' in section 16(2)(c) be deleted. A member of the board should not use *any* information obtained because of the performance of his functions for his own profit. There are always debates about whether certain information is confidential or not because people do not always think to mark documents as confidential or to stipulate that what they are saying is confidential. No member of the board should be allowed to profit personally from his or her position on the board irrespective of the nature of the information concerned.

157. It is recommended that a subsection (4) be added to section 16 that reads as follows:

'(4) Every member of the board must:

(a) act with good faith, due care, skill and diligence in executing the work of the board;

(b) conduct himself or herself in a manner that promotes and maintains the integrity of the board at all times;

(c) avoid conflicts of interest; and

(d) must act independently and free from bias in his or her role as a member of the board.

158. The words 'in consultation with the Minister' in section 17 must be deleted. The board must be free to determine its own procedures without political influence.

159. The board, not the Minister and not Cabinet, must appoint the CEO. Section 19 does not make this clear. A person must hold office subject to the directives and determinations

of the board (section 19(4)(b)), without the influence of the Minister. The words 'in consultation with the Minister' should therefore be deleted from section 19(4)(b). The CEO must be accountable only to the board. The Minister must have no capacity to intervene in the relationship between the board and the CEO. This creates opportunities for corruption and political interference between the board and the CEO, and undermines the power the board must have over the CEO if it is to practise effective corporate governance of the fund.

160. Section 19(5) should be amended to read as follows –

'The board may remove the CEO from office if he or she:

(a) becomes disqualified for office in terms of any law or is convicted of a criminal offence;

(b) fails to perform the functions of his or her office in good faith or in the public interest or in accordance with applicable law or the fund's code of ethics; or

(c) becomes unable to perform the functions of his or her office by virtue of mental or physical impairment or because he or she has been found guilty of misconduct by the board or because he or she has acted dishonestly or has used his or her position for personal gain.'

161. With regard to section 20(1) the CEO as *executive* not *administrative* head of the fund must report to the board *at each meeting* of the board, which is recommended to take place once every two months (six times a year). Four times a year is not a sufficient number of board meetings. It is recommended that this board must be very hands on in order to ensure proper corporate governance of the fund.

162. Section 20(3) should be amended to the effect that the CEO must ensure that the *functions* of planning, benefit design and provider payment, among others, are carried out by the fund. The actual structure of the fund must follow upon the strategic plans of the fund. There is no need to shackle the CEO by requiring in legislation that specific units are created within the fund. The law should not dictate the corporate structure of the fund. There is a need for the operational structure to be flexible and adaptable to the changing needs of the fund. Legislation must not restrict the internal structures of the fund.

163. With regard to section 20(4), the CEO must be responsible not for the assets and liabilities of the fund but for the protection, management and maintenance of its assets and the management and discharge by the fund of its liabilities. As currently written, this section makes it seem as though the CEO is personally responsible for discharging the liabilities of the fund.

164. With regard to section 20(5) the CEO should be concerned with the health care needs of *beneficiaries* and not the *population* and must report on the number of *contracted* (not approved) health care providers.

165. The words 'or advisory' should be inserted after the word 'technical' in section 24(1)(a). Section 24(1)(b) should be deleted. The board should not have to follow the same procedures as the Minister, as outlined in section 29, when appointing technical and advisory committees under section 24. The fund should pay members of technical and advisory committees appointed by the board in terms of section 24 and should be free to determine the composition, functions and working procedures of each such committee without having to put notices in the Gazette.

166. With regard to section 25, the Benefits Advisory Committee must not sit outside of the fund. It must be subordinate to the board. The Minister must be obliged to call for nominations from the general public of persons to be appointed to the Benefits Advisory Committee. In section 25(5) the words 'The Benefits Advisory Committee must determine and review…' must be changed to read 'The Benefits Advisory Committee must make recommendations to the board regarding and review…'.

167. The Benefits Advisory Committee must not be able to determine benefits because it has no accountability for the financial sustainability of the fund. The board should be able to terminate the appointment of a member of the Benefits Advisory Committee on grounds of misconduct because the board should be able to evaluate the performance of the members of the Benefits Advisory Committee. There must be a limit to the number of persons that can be appointed to the Benefits Advisory Committee. BHF recommends that the limit is 13 persons. Committees that are too large do not function well and can get bogged down. We also recommend that instead of having one person on the committee to represent the Minister, an employee of the Department of Health at deputy director-general level be appointed to the committee. Such a person is likely to be conversant with national health policy and knowledgeable on matters of national

importance relating to health care. An employee of the fund should also be on this committee in order to ensure continuity of information between the committee and the fund.

168. In section 25(5)(c) the words 'in consultation with the Minister and' must be deleted. The Minister of Health is not an expert on health care funding or benefit design. He is a politician and a member of Cabinet. The benefits offered by the fund must be determined in a manner that avoids political intervention. It is not appropriate for the Minister of Health, as a provider of health care services via central hospitals, to dictate the benefits provided by the fund.

169. Section 26 needs to be amended to include a mechanism for getting rid of a member of the Health Care Services Pricing Committee if he does not conduct himself properly. The board is the most appropriate mechanism for this even though the Minister appoints the members. The board can constitute a disciplinary committee to deal with members of the Benefits Committee and the Health Care Benefits Pricing Committee and determine the procedure for terminating a member's appointment. The Minister must not be burdened with such procedures.

170. BHF also feels that it is necessary to include expertise in pharmacy and benefit design on the Benefits Pricing Committee and that the reference to labour is inappropriate and should be deleted. It is not necessary to have a labour expert in a committee of this nature and it could even cause problems because the unions will each want to have their 'representative' and employer organisations will each want to have their 'representative' on the committee. Organised labour is provided for in the Stakeholder Advisory Committee and we submit that this is where it belongs. The Health Care Benefits Pricing Committee should essentially be an expert technical committee that is knowledgeable about health benefit design, pricing and health financing. We believe that the committee must explicitly be given the power to conduct research into pricing of health care goods and services before making its recommendations and that the purpose of its recommendations should be to ensure the most effective and efficient utilisation of the fund's resources.

171. It is essential to preclude from membership of this committee people who have a vested interest in its recommendations hence we propose that a member of the Health Care Benefits Pricing Committee should not be an employee, officer, director, agent or owner

of a contractor to the fund. There should be provision in the bill for how this Committee conducts itself, i.e. in good faith and with due care, skill and diligence and the avoidance of conflicts of interest. See our attached version of the bill where we indicate in red the changes that must be made in this regard.

172. Sections 31(1)(a) and (b) must be deleted. They are inappropriate and unnecessary. The board, not the Minister, is responsible for the governance of the NHI fund.

173. Section 31(2) is unconstitutional. The Minister, as a member of the National Executive, cannot make law. Parliament makes law. The Minister can only initiate legislation. Section 31(2) should be amended to read:

'National legislation must appropriately delineate the respective roles and responsibilities of the Department and the provincial departments of health in a manner that prevents unnecessary duplication of health care services and ensures optimal utilisation of health care resources and the equitable provision and financing of health care services.'

174. Section 32 should be deleted. It belongs in the NHA and not the bill. The role of the national Department of Health is set out already in the NHA and any changes to the department's role must be reflected in amendments to that Act.

175. Section 33 should be deleted. It is unconstitutional for the reasons already given. Medical schemes should not be restricted to complementary cover.

176. Section 34(1) is too vague. What is it that the fund must contribute to the development and maintenance of the national health information system? Money? Time? Personnel? Information? BHF is opposed to the fund contributing any of these to the development and maintenance of the national health information system. This is the responsibility of the national Department of Health. The fund must have its own information systems for which it is responsible. The whole of section 34 is inappropriate and unnecessary and should be deleted. It is unnecessary to require health care providers and others to comply with the NHA. This Act does not need to be propped up or reinforced by the NHI Bill. It is a law in its own right.

177. Section 35(1) consists of needless repetition and should be deleted. It is already stated in section 4(1) that the fund must purchase health care services. The words 'actively and strategically' are meaningless in law.

178. Section 35(2) says that the fund must 'transfer funds directly to accredited and contracted central, provincial, regional specialised and district hospitals based on a global budget or diagnosis-related groups'. What is meant by a 'global budget'? This term is not defined and could be read to mean the entire budget of a provincial health department. This totally contradicts the concept of the purchaser/provider split. This section does not make provision for payments to the provincial governments that own these facilities. Provincial, regional and district hospitals are not juristic persons and don't have their own bank accounts. Furthermore, they do not have the legal, administerial and managerial capacity to manage their own funds. It is the provinces that manage them financially and it is the provinces that own them. The provincial governments are the ones with legal capacity. In law one cannot contract with or make payments to a hospital with no juristic personality. One cannot owe a debt or have a right to payment unless one has juristic personality.

179. The use of the phrase 'transfer funds' in section 35(2) is deeply disturbing. It suggests that there will not be a purchaser/provider contract between the hospitals and the NHI fund. The NHI fund will therefore effectively not be a purchaser of health care services from these hospitals so much as a conduit for the flow of money to them - regardless of their performance, their capacity to service NHI beneficiaries, the quality of the health care they provide and their compliance with basic standards. A contract would ensure the accountability of these hospitals for their performance, adherence to standards and the like. The NHI fund could terminate the contract if they fail to comply. In the absence of a contract there is no accountability, no performance management or performance assessment. The NHI fund will just be 'giving' them money. The words 'global budget', whatever 'global' means, suggest that the NHI fund will be paying them on the basis of a budget rather than paying them for health services that they provide. This 'global budget' could include capital expenditure, infrastructure maintenance and other items for which the NHI fund should not be paying. This obliterates the purchaser/provider split principle that was endorsed by the White Paper on NHI. The NHI fund must purchase health care services, not fund the entire public health system.

180. Writing diagnosis related groups (DRGs) into legislation, as is proposed in section 35(2), is unwise. There are many different forms of alternative remuneration for health care services. DRGs make up just one of them. The term is not defined in the bill. In the health care industry this term has a widely recognised technical meaning. As used in the bill, however, it will not necessarily have the same meaning. The reference to DRGs should be deleted.

181. The NHI fund must *purchase* health care services from the provincial governments that own the hospitals. It cannot subsume the role of the national revenue fund and the DORA by simply *transferring* money to public health establishments. It is not the role of the NHI fund to finance capital expenditure on health care service and infrastructure in the provinces. A purchaser is not responsible for funding a provider's operations. The provider must fund its own operations from a variety of sources. A purchaser of health care services must not purchase the equipment and infrastructure necessary to render those health care services. That is not what 'purchaser/provider' split means. The fiscus must fund the infrastructure costs and capital expenditure of public health care establishments. Section 215 of the Constitution makes provision for national legislation to prescribe the form of national, provincial and municipal budgets and that budgets of each sphere of government must show the sources of revenue and the way in which the proposed expenditure will comply with national legislation. Budgets in each sphere of government must contain estimates of revenue and expenditure differentiating between capital and current expenditure.

182. The functioning and administration of public health establishments are the financial responsibility of the provinces yet the NHI Bill amends the functions of the national Department of Health to include controlling and managing the cost and financing of these establishments and agencies. This means in essence that the provinces will no longer have control over the cost and financing of them, which means in turn that they will no longer have control over the financing of health public health care services since these services are rendered in public health establishments. But they will still have a constitutional responsibility to provide basic services. How can they do so, if they do not have control and management capability over their costs? Their constitutional mandate is distinct from the constitutional mandate of national government.

183. Section 35(2) of the NHI Bill should be amended to read: 'The fund must pay for health care services rendered by provincial, regional, specialised and district hospitals in accordance with the provisions of the Public Finance Management Act, No 1 of 1999.'

184. Section 7 of the PFMA states that:

(1) The National Treasury must prescribe a framework within which departments, public entities listed in schedule 3 and constitutional institutions must conduct their cash management.

(2) A department authorised to open a bank account in terms of the prescribed framework, a public entity or a constitutional institution may open a bank account only:

- (a) with a bank registered in South Africa and approved in writing by the National Treasury; and
- (b) after any prescribed tendering procedures have been complied with
- (c) A department, public entity listed in Schedule 3 or constitutional institution may not open a bank account abroad or with a foreign bank except with the written approval of the National Treasury.

185. Section 22 of the PFMA states that:

(1) All money received by a provincial government, including the province's equitable share, and grants made to it, in terms of the annual Division of Revenue Act, must be paid into the province's provincial revenue fund, except money received by:

- (a) a provincial public entity in the province;
- (b) the provincial government from donor agencies, which in terms of legislation or the agreement with the donor must be paid to the Reconstruction and Development Programme fund;
- (c) a provincial department in the province:
  - (i) operating a trading entity, if the money is received in the ordinary course of operating that entity;
  - (ii) in trust for a specific person or category of persons or for a specific purpose;
  - (iii) from another department to render an agency service on behalf of that department;
  - (iv) in terms of the annual Division of Revenue Act, if the money is exempted by that Act from payment into the revenue fund; or
  - (v) if the money is of a kind described in schedule 4.

(2) The exclusion in subsection (1) (b) does not apply to a provincial public entity in the province which is not listed in schedule 3 but which, in terms of section 47, is required to be listed.

(3) *Draft legislation that exempts money from payment into a provincial revenue fund may be introduced in Parliament only after the Minister has been consulted on the reasonableness of the exclusion and has consented to the exclusion*.

(4) *Any legislation inconsistent with subsection (1) is of no force and effect to the extent of the inconsistency.*

(5) Money received by a provincial public entity listed in schedule 3 must be paid into a bank account opened by the entity concerned (our italics).

(6) The NHI Bill does not amend the PFMA.

186. Section 35(4)(a) of the bill states that emergency medical services must be reimbursed on a capped case-based fee basis. This is an operational issue that does not belong in legislation. The fund must determine how best to pay for services it purchases. Section 35(4)(a) must be deleted. The law should not dictate reimbursement mechanisms to the fund. The fund must be free to decide on reimbursement mechanisms.

187. BHF submits that the creation of DHMOs will unnecessarily increase the administration costs of the fund. There is no indication of who these offices will report to in section 36. It simply establishes them as national government components in a vacuum. Will they report to the national Department of Health or the NHI fund? How will they be structured? There are no clear reporting lines for DHMOs. How do they relate to the District Health Councils established in terms of the NHA? Are they intended to replace them? Do they sit on the funding side of the equation or the health provision side? How will they be funded and by whom? How do they relate to district municipalities that must provide municipal health services (non-personal health services)? Non-personal health services are not the concern of the fund and the fund should not be paying for them.

188. BHF does not support the concept of CUPHCs as set out in section 37. They are impractical and ill-conceived. They require a level of organisation of providers at district health level that simply does not exist. There is also a distinct lack of clarity around the role of CUPHCs, what they actually are and how they will be managed. CUPHCs are not created as juristic persons but seem rather to comprise a kind of network of health care providers. One cannot contract with something that does not have juristic personality. What

happens if these networks do not form? Will the fund then simply not pay for primary health care in that geographical area? District hospitals do not have legal personality; neither do clinics or community health centres. How will the fund pay CUPHCs if they have no legal personality? Will CUPHCs distribute the money from the fund to contracted providers? If so they will need financial management expertise. This is just another level for corruption to take hold.

189. The relationship between DHMOs and CUPHCs is vague. Do the DHMOs manage the CUPHCs? Are DHMOs intended to replace provincial departments of health? What role will provincial health departments play in relation to CUPHCs? The provincial departments own and administer district hospitals and clinics. Who will manage the funds that are 'transferred' by the fund to the CUPHCs? Where will the management structures be located? In the CUPHCs or in the DHMOs? The CUPHCs must 'manage contracts' entered into with accredited health care service providers but, on the other hand, the CUPHCs consist of accredited health care service providers? This is confusing. What is meant by a 'horizontal network' in section 37? This phrase is meaningless in law. How will the CUPHCs be organised and who will govern them? One cannot force providers to become part of a network if they don't want to or it is not practical for them to do so. BHF submits that CUPHCs are, in any event, on the provider side of the purchaser/provider split and therefore do not belong in the NHI Bill. They properly belong in the NHA. Consequently section 37 should be deleted.

190. The words 'in consultation with the Minister' must be deleted from section 38(1). The board must not be hamstrung by the Minister. The board must run the NHI fund. There must be no room for political influence in the procurement work of the fund. Room for political interference creates room for corruption and mismanagement. The Minister of Health must not in any way be able to intervene in the work of the fund. He does not have the necessary expertise, knowledge or skill and is, first and foremost, an elected politician.

191. It is not clear why section 38(2)(f) requires the Office of Health Products Procurement to support DHMOs in concluding and managing contracts with suppliers and vendors. What is the role of the provincial health departments in procurement? Who do the DHMOs report to? The schedule to the bill that amends the NHA to create DHMOs does not state how many are to be created or how they are related to the fund or the provincial health

departments. It is not clear whether DHMOs are on the purchaser or the provider side of the purchaser/provider split. The bill states that DHMOs must manage provision of non-personal health services in the district but this is a role that is constitutionally assigned to district municipalities. The fund must not pay for non-personal health services in any event. Municipalities must do so through municipal rates and taxes. The bill demonstrates no appreciation of and alignment with the role of district municipalities, which is clearly set out in other legislation. There is also the issue of the funding of the capital expenditure of providers by the fund. BHF submits that the fund should not be purchasing equipment of a capital nature for the public health sector. What is meant by 'high-cost' devices and equipment? This phrase has no meaning in law. How does one tell whether a device or equipment is 'high cost' or not? What makes a device 'high cost' and how high must the cost be in order to be considered 'high'?

192. Section 39 deals with accreditation of providers. BHF has already made the point that it does not support accreditation in isolation from contracting. There is no point in being accredited by the fund unless this implies that there will be a contractual relationship flowing from accreditation. What is the relationship to the fund of a provider who is merely 'accredited' without also being contracted to the fund? The work of the OHSC to *certify* heath care providers and health establishments will be a massive undertaking for which it is not currently adequately equipped. Below is a summary from our PCNS data on the numbers of providers and establishments that will have to be certified.

	PARTNER	SOLUS		Grand Total
Row Labels	**Private**	**Govt**	**Private**	
Approved U O T U / Day Clinics			113	113
Drug & Alcohol Rehabilitation			93	93
Group Practices/Hospitals	133			133
Hospices			52	52
Mental Health Institutions			59	59
Nursing Agencies/Home Care Services	2		58	60
Pharmacies	1		3649	3650
Private Hospitals (A - Status)			95	95
Private Hospitals (B - Status)			162	162
Private Rehabilitation Hospital (Acute)			12	12
Provincial Hospitals		406		406
Sub-Acute Facilities			96	96
Unattached Operating Theatres / Day Clinics			8	8
Grand Total	**136**	**406**	**4397**	**4939**

Note: Only 406 State hospitals are listed on the PCNS – there will obviously be many more, as district and primary care clinics will also need to be certified.

In relation to private practitioners the summary is below:

Group	Number of Individual Practitioners	Number of Group Practices and Partnerships	Individuals Linked to Groups and Partnerships	Minimum Number to License / Accredit
Anaesthetists	1 494	106	247	1 353
Dental Specialists	1 322	60	43	1 339
Dentists	3 682	396	480	3 598
General Practitioners	13 085	1 257	1 905	12 437
Medical Specialists	4 513	368	461	4 420
Medical Technologists	102	10	15	97
Pathologists	227	45	105	167
Radiologists	870	146	211	805
Supplementary and A..	31 496	1 967	2 597	30 866
Surgical Specialists	3 095	252	336	3 011
Total	**59 886**	**4 607**	**6 400**	**58 093**

193. These numbers will be the same for accreditation if the fund then subsequently has to accredit these providers/establishments. The certification and accreditation processes will hinder the implementation of NHI simply because of the logistics involved. BHF recommends that the notion of accreditation be deleted from the bill and that providers must simply be certified by the OHSC and contracted by the fund.

194. The bill ignores the fact that public health establishments do not have juristic personality. In law, contracts can only be made between persons yet section 39(3) says that the fund must conclude a legally binding agreement with a 'health establishment' certified by the OHSC. This does not make any sense. Health establishments do not have legal personality unless they are registered as companies or acquire the capacity to contract by virtue of some other law like the PFMA. Section 39(3) demonstrates a total ignorance of basic legal principles. As already noted, CUPHCs do not have legal personality either.

195. It is totally contrary to the principles of the law of contract to dictate the terms of a contract in legislation. If the terms of a contract are dictated in legislation then there is no contract, because contracts are by definition a list of terms to which both parties have

agreed. The power of the fund to negotiate and enter into contracts with providers and suppliers must not be restricted by the provisions of the bill or regulations. Contractual powers by their nature are flexible and must be exercised with regard to different circumstances. Therefore sections 39(4) and 39(6) must be deleted. They are inappropriate and unnecessary. The fund must be free to terminate a contract with a provider *at any time* if the provider fails to comply with its terms. The fund must not have to wait five years before it can terminate a contract. This is another reason why accreditation as a separate step is not recommended. The fund must be free to contract with a duly licensed provider that meets the operational and other standards expected as identified by the OHSC or any other standard imposed by the fund. The OHSC is not going to be able to inspect and certify all GP practices, for example. Logistically speaking this is simply not possible. The fund must nevertheless be able to enter into contracts directly with GPs. The standards required of these GPs must be specified in the contract itself. Prior accreditation is not practical.

196. Sections 39(7), 39(8), 39(9), 39(10) and 39(11) should be deleted. A system of provider accreditation imposes too much of an administrative burden on the fund and will unnecessarily increase the fund's administration costs. The fund should control providers through a contracting process only. If the provider does not deliver, penalties can be built into the contracts and ultimately termination of the contract is also an option. Accreditation is too cumbersome. The fund should be able to decide for itself which providers it wishes to contract with and on what basis. The fund must have full contractual powers that are unfettered by legislation.

197. Section 40(2) should refer to the NHA, which also has provisions around the protection of health information. It should therefore read: 'Heath care service providers must submit to the fund such information as may be prescribed, taking into consideration the provisions of the POPI Act (Act No 4 of 2013) and the NHA (Act No 61 of 2003).'

198. Section 40(3) refers to referral networks 'prescribed' by health care service providers. Health care service providers cannot make regulations. The word 'prescribed' means 'prescribed by regulation'. Health care providers should not determine referral networks because they have a vested interest in what the referral pathways are. Also, referral networks as determined by health care providers may vary from one provider to another

and there will therefore be a lack of consistency. They should rather be prescribed by the Minister in regulations.

199. Much of what is contained in section 40(4) is already in the NHA and therefore unnecessary. It is also awkwardly written as it says that no 'third party' may disclose information contemplated in subsection (2). What is meant by a 'third party'? The fund itself should be bound by rules of confidentiality. The POPI and the NHA already contain protections for the confidentiality of beneficiary information and it is therefore unnecessary to repeat them in the NHI Bill. The words 'third party' suggest that the fund is not included. The word should be 'no-one' rather than 'third party'. Section 40(4) should be deleted. Section 40(5) is also unnecessary because other sections of the bill already provide for fraud and risk management - for example section 20(3) and section 20(2). Section 40(6) should also be deleted. It does not belong in legislation. It is operational detail that belongs in policy documents.

200. The words 'in consultation with the Minister' in section 41(1) must be deleted. There must be no political influence on the activities of the fund. Section 41(2) should be deleted. BHF is opposed to accreditation of providers as a separate process from contracting because it will add unnecessarily to the administrative costs of the fund without adding any value. Section 41(3) should also be deleted. BHF does not support the concept of CUPHCs and it is submitted that section 41(3) contains operational issues which must be determined by the fund outside of legislation. The fund must be free to conduct its operations in the manner that best fits the circumstances. Being overly prescriptive in law will just hobble the fund in its power to adapt to different circumstances. It is not appropriate for legislation to dictate how the fund pays providers. This must be specified in the terms of the contract that the fund enters into with providers.

201. Section 41(4) is also totally unnecessary and gives the Minister the power to govern contracts entered into by the fund. This is highly inappropriate. The fund's operations should not be dictated down to the last detail by legislation. The fund must have room to negotiate contracts in a manner that is in the best interests of beneficiaries. Section 41(4) must be deleted. A contract should not be dictated by legislation because then it is no longer a contract. The fund must be free to vary contractual terms as the situation requires. The Minister should not be allowed to make any of the regulations contemplated in section 41(4).

202. There is a mistake in section 46. The words 'appeal tribunal' should be substituted for the word 'board' in the third line.

203. Sub-paragraph 48(d) must be deleted. The fund should not be allowed to keep money erroneously paid to it. It is not aligned to good governance or ethical leadership.

204. With regard to section 49(2)(ii), it is noted that tax credits are not paid to medical schemes. Section 49(2) as a whole is unnecessary and inappropriate and should be deleted. It is sufficient to say that the fund will be entitled to money appropriated annually by Parliament. It should be up to the National Treasury to decide how best to finance the NHI. The shifting of funds from the provincial equitable share could be unconstitutional. The bill should avoid being too prescriptive in respect of how money for NHI is found. These provisions are best contained in a money bill, which, according to the Constitution is required for the raising of money. The NHI Bill is not a money bill and so should not contain provisions that should be in a money bill.

205. Section 55 (1)(d) is badly written. It is not the responsibility of the fund to develop and maintain the national health information system. This is the responsibility of the national Department of Health as evidenced from the amendment to the NHA contained in the schedule to the bill. Section 55(1)(d) should therefore be deleted. Section 55(1)(b) must also be deleted. The Minister should have no power to regulate the operations of the fund, including the reimbursement mechanisms it uses to pay providers. Section 55(1)(g) should also be deleted because accreditation of providers by the fund is unnecessary as stated previously.

206. The fund must have the power to enter into contracts with providers it believes can deliver the required health care services. The OHSC already exists and providers are required to meet various standards under the NHA. If a provider meets those standards and, where appropriate, is certified by the OHSC then why should any further accreditation be necessary? Regulation 55(1)(x) is totally inappropriate because it undermines the provisions relating to the Benefits Advisory Committee and other committees. The Minister must not have the power to make regulations on the scope and nature of prescribed heath care services and the manner and extent to which they must be funded. This is the work of the Benefits Advisory Committee and the other committees created in the bill together with the fund itself. Section 55(1)(x) must be deleted. The fund must be able to design benefits according to the available resources at its disposal.

207. The provisions set out under section 57, Transitional Arrangements, do not belong in the bill. They belong in policy documentation, not law, and should therefore be deleted. Normally the transitional arrangements section of a statute contains provisions for the change in an existing legislative framework to a new legislative framework. They do not set out the government's operational plans for implementing the new legislation. It is not appropriate to include implementation plans in law. They belong in policy documents and other documents outside of the legislation.

208. BHF does not accept the proposed amendments to the Medical Schemes Act as set out in the schedule to the bill. For the reasons already stated, allowing medical schemes to provide only complementary cover is unconstitutional.

209. The amendment to the Medicines Act in the NHI Bill makes no sense because it eliminates the bargaining power of the NHI fund to obtain medicines more cheaply than at the single exit price. The notion of a single exit price means that the fund is not allowed to pay less than the single exit price for medicines. This handicaps the fund. The single exit price system has never applied to the State. It is only currently applicable in the private sector. The State has always used a tender system to purchase medicines and usually obtains them for less than the single exit price. Why impair the bargaining power of the NHI fund by forcing it to purchase medicines at a set price? In the private sector, the single exit price system has acknowledged weaknesses. It has led to problems where pharmaceutical companies cannot offer any discounts, including bulk discounts, even if they want to. They cannot do special deals on particular medicines, e.g. antiretrovirals or expensive biologicals, because they are bound by the single exit price. One of the main objects of having a single NHI fund is to create monopsony purchasing power. What is the point of having such power if it cannot be used effectively?

210. The single exit price legislation limits price negotiation and as a result dampens price competition, particularly for innovative medicines where no generic alternatives are available. A multinational pharmaceutical company typically sets the price based on international pricing standards, economic value propositions and corporate pricing policies. There is provision in section 11(2) for the fund to negotiate 'the lowest possible price for goods and health care services' but the system of having a single exit price negates this provision as far as medicines are concerned.

211. Experience suggests that medicine prices could be lower if price negotiation between market participants was permitted. Some multinational pharmaceutical companies would be willing to accept a price lower than the suggested single exit price for medicine if it were reimbursed by large medical schemes. That is, the manufacturer would be willing to accept a lower price in exchange for greater volume reimbursed by the medical scheme. However, the current regulatory framework is a significant deterrent to price negotiation and prevents patients from obtaining better prices for biological medicines and potentially many other medicines on the market.[15]

212. The single exit price system has been criticised by Andy Gray, senior lecturer at the University of KwaZulu-Natal's School of Health Sciences and a research associate at the Centre for the Aids Programme of Research in SA, because the initial single exit price is at the discretion of the manufacturer or importer and is based entirely on their own commercial calculations, relative to possible competitors. He points out: 'There is no accounting for any costs incurred, whether in development, manufacture or marketing, and such costs are confidential.' The whole point of this system is to have only one price for private sector buyers – not to have a cost-reflective or fair price. Civil society groups such as the Treatment Action Campaign (TAC) and Section 27, which helped bring at least one of the three cancer drugs in question to the Competition Commission's attention, have long doubted the single exit price system. The TAC and Section 27 do not support the current system by which the initial single exit price is completely discretionary and untransparent – and whereby prices can be set at levels unaffordable to most of the population.[16]

213. BHF urges that the NHI fund be allowed to negotiate the supply of medicines below the single exit price. There is still a need for the single exit price to apply in the private sector in respect of medicines not purchased through the NHI. The single exit price does not allow for volume discounts and other special prices. The NHI fund should be able to use its purchasing power to keep the prices of medicines as low as possible, even if this is lower than the single exit price. For this reason, the amendment of section 22G by the substitution of subsection (3)(a) should read:

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[15] https://www.carapinha.com/single-exit-price-legislation-a-source-of-harm-to-competition/
[16] https://www.fin24.com/Companies/Health/can-competition-law-fix-sas-drug-price-problem-20170618-2

'(a) The transparent pricing system contemplated in subsection 2(a) shall include a single exit price which shall be published as prescribed by the Office of Health Products Procurement contemplated in subsection (1) and such price shall be the *maximum* price at which manufacturers shall sell medicines and scheduled substances to the National Health Insurance fund established by section 9 of the National Health Insurance Act, 2019 or any other person.'(our italics)

214. Section 56 is too wide and non-specific. It is likely to be unconstitutional. It does not say who must comply with these directives by the fund, to whom these directives must be issued or on what subject the fund may make directives. These directives cannot have the status of law because only Parliament has the power to make law. Can the fund issue a directive to the Minister for instance, or to the national Department of Health? It is suggested that section 56 be deleted and instead under section 15 of the bill dealing with the functions and powers of the board a subsection (5) is added which reads:

(7) The board may issue directives in terms of this Act relating to the implementation of national health insurance or the administration of the fund which must be complied with by the CEO, a committee of the board or employees of the fund as the case may be.

215. Section 57 deals with transitional arrangements. It is not appropriate to include provisions in law that refer to the past, yet section 57 (2)(a) refers to the period 2017 to 2022. It is already 2019. In our legal system there is a strong presumption against the retrospective application of the law because a person cannot go back into the past and do something he should have done then, but did not. Also, if the Minister of Health does not comply with Phase I, then he has broken the law. For this reason, it is recommended that section 57(2) be deleted. Thus, it can still be clear from section 57(1) that the NHI must be implemented in phases, but year values should not be attached as they are in 57(2). In the event that the implementation does run a bit behind schedule, the government cannot be taken to task for not following the NHI Act to the letter regarding years of implementation. The year numbers should rather be associated with each of the phases in a policy document. Indeed, the whole of section 57(2) belongs in policy not law. Policy is what government determines in order to decide how to go about implementing a law. It forms part of the planning surrounding the law but should not be part of the law. Government should be allowed to make policy unrestricted by legislation. Law should not determine policy. In the normal order of things government policy is the basis on which

the content of legislation is determined. Policy is wider than law and serves a different purpose.

216. Section 57(3) does not belong in legislation. Under the NHA the Minister is empowered to establish such advisory and technical committees as may be necessary to achieve the objects of that Act. It is submitted that a section should rather be inserted after section 56 in the bill that says the same thing, i.e.:

‘(1) The Minister may establish such number of advisory and technical committees as may be necessary to achieve the objects of this Act.

(2) When establishing an advisory or technical committee, the Minister may determine by notice in the Gazette:

(a) its composition, functions and working procedure;

(b) in consultation with the Minister of Finance, the terms, conditions, remuneration and allowances applicable to its members; and

(c) any incidental matters relating to that advisory or technical committee.”

The current contents of section 57(3) belong in a policy document on NHI implementation.

217. Section 57(4) belongs in policy documentation not law. It is not appropriate to include all policy in legislation because law and policy serve two different purposes. Law states what *must* be done and policy sets out government’s intentions on how it is going to go about it. Policy objectives do not belong in law. Law is binding on everyone. The law should not go into excruciating detail about how the Minister of Health must do his job. His job in broad terms is to implement national legislation. That entails a vast number of actions and policy decisions that do not belong in legislation. For example, it is not necessary to legislate, as has been done in section 57(4)(h), that a list of national legislation must be amended. The Constitution already gives to Parliament the power to amend or enact legislation and to the Minister of Health the power to initiate changes to legislation. It is not necessary to legislate the migration of central hospitals that are funded, governed and managed nationally as semi-autonomous entities. These things belong in policy documentation. Policy does not have to be as precise in its language usage as law must be.

The Competition Act

218. There is clearly a need for competition law to apply to sellers of medicines and health products purchased by the NHI fund. See examples below. The statement in section 3(5) of the bill that the Competition Act does not apply to any transactions concluded in terms of the NHI Bill is too wide. The Competition Act can prevent pharmaceutical companies from trying to hold the NHI to ransom. It can support the NHI fund if health care providers and other suppliers are subject to the Competition Act. For example:

- Aspen Pharmacare was accused of price gouging by the Spanish National Health Service and by the State-controlled Italian Medicines Agency (AIFA) in 2017. At issue was the drug company's demand for huge price increases of up to 4000% for five cancer drugs for which there are no alternative therapies. Aspen used strong-arm tactics on the Spanish Health Service by withholding supplies of the five drugs. *The Times* reports that this prompted an employee at Aspen's European head office in Dublin to ask a senior executive what should be done with existing stocks of the drugs in Spain. The executive's response, notes *The Times,* was: 'The only options will be to donate or destroy this stock.'

  The report says the drugs in question are known as the Cosmos portfolio, for which Aspen bought the rights from GlaxoSmithKline for £273m in 2009. The portfolio encompasses mercaptopurine, used to treat acute lymphoblastic leukaemia, a disease confined to children, busulfan and chlorambucil, for treating leukaemia, and drugs for cancers that occur primarily among the elderly.

  According to Aspen, the Cosmos portfolio produced revenue of €60m in the EU in its year to June 2016. It represented 2.7% of total group revenue.

- Aspen's run-in with Spanish health authorities is not the only price-gouging incident it has been accused of. In 2014 it also locked horns with the AIFA in a bid to raise the prices of four of its Cosmos drugs by 300-1500%. Aspen eventually largely got its way, but fell foul of Italy's competition authority which, following a lengthy probe, ruled that the pharmaceutical group had at times created shortages of the drugs and threatened to stop supplying them altogether if the AIFA did not bow to its demands.

  Giovanni Codacci-Pisanelli, assistant professor in medical oncology at the University of Rome, had harsh words for Aspen. The report says media group *EU Reporter* quoted him as saying: 'One of the main criticisms against Aspen Pharma is that they did not ask for an updating of the drug price using the available legal instruments, but rather

chose to use aggressive behaviour that jeopardised the availability of these life-saving and irreplaceable agents.' The Italian competition authority slapped a €5.2m fine on Aspen in October 2016 for abuse of its monopoly position and price gouging. It lost its appeal against the €5.2m fine levied by the Italian Competition Authority in 2016 for excessive pricing and faces an ongoing probe by the European Competition Commission for steep price hikes in several off-patent cancer drugs it acquired from GlaxoSmithKline.

- In December 2016 the UK Competition and Markets Authority (CMA) imposed a record fine of £84.2 million on pharmaceutical manufacturer, Pfizer, and a fine of £5.2 million on distributor Flynn Pharma, for charging excessive prices for a generic anti-epilepsy drug, phenytoin sodium. These companies increased prices up to 2600% between 2012 and 2013 after de-branding of the drug. The CMA could not find any justification for the significant price increases as these were old drugs without recent innovation or investment costs to recoup.
- The above excessive pricing cases involving Pfizer in the UK, and Aspen Pharmacare in the EU and Italy, all relate to generic drugs. Generics are expected to be cheaper than patent or branded drugs because they can be manufactured by any company, not just the developer of the original drug. Price competition between multiple manufacturers is expected to lower prices of generics, which is why they are not subject to price regulation.[17]
- In 2019 Aspen Pharmacare was ordered to pay a fine of £8 million to the UK's National Health Service (NHS) for anti-competitive behaviour. Aspen's agreement to pay the NHS followed an investigation by the CMA into alleged anticompetitive behaviour by Aspen and two rival pharmaceutical companies over fludrocortisone, a drug used to treat Addison's disease. The CMA said it suspected Aspen had paid competitors to stay out of the market in 2016, enabling it to set prices.

  The CMA said Aspen had recently approached it with an offer to resolve the matter. It said Aspen admitted by way of settlement that it was party to an illegal, anticompetitive agreement. In addition to paying the NHS, it agreed to restore competition by opening the market for fludrocortisone to at least two other competitors. The CMA said it was

[17] https://www.competition.org.za/review/2017/12/20/excessive-pricing-in-the-global-pharmaceutical-industry

still investigating Aspen, which could face a fine of up to £2.1m found to have broken the law.[18]

'The CMA launched this investigation because we consider it unacceptable for the NHS — and the taxpayers who fund it — to have to pay millions of pounds more than they should for this life-saving drug,' CMA CEO, Andrea Coscelli, said in a statement published on its website.

- Aspen is by no means the first generic pharmaceutical company to come under fire for ramping up prices. Others include Canadian generic group Valeant, which in 2010 acquired the rights to cuprimine and syprine, the only drugs available for the treatment of the rare Wilson's disease. If untreated it is deadly. Valeant hiked the price of cuprimine by 2849% and that of syprine by 1424%. It ramped up the cost of a year's supply of the drugs to about $300 000.[19]

219. In June 2017, the Competition Commission of South Africa launched an investigation into three major pharmaceutical companies for alleged excessive pricing of cancer drugs – Roche, Pfizer and Aspen Pharmacare. Roche, a Swiss company and Pfizer, an American company, are two of the largest pharmaceutical companies in the world. Aspen Pharmacare, a South African company, although not in the global top 20 pharmaceutical companies, is the sole manufacturer and supplier of off-patent drugs for blood, bone marrow and ovarian cancers. Aspen acquired the license and marketing rights from the originator GlaxoSmithKline after the patents expired in 2009.

220. All three companies have sole rights to distribute different cancer drugs in South Africa. Roche and Pfizer are sole suppliers of the breast and lung cancer medicines, respectively, while Aspen Pharmacare is the only supplier of three generic cancer medicines. The investigation follows a number of similar investigations against the same companies by other competition authorities internationally, including the European Commission (EC), the Italian Competition Authority and the UK's CMA.

221. The Competition Commission of South Africa dropped charges against Aspen Pharmacare in October 2017, observing that an excessive pricing case could not be sustained. The

[18] https://www.businesslive.co.za/bd/companies/2019-08-14-aspen-shares-fall-to-five-month-lows-on-8m-anti-competitive-fine/

Commission noted that the revenues generated by the drugs in question (Myleran, Alkeran and Leukeran) were very low, due to few patients using the drug. Furthermore, the drugs presented limited prospects in the market as they were approaching end of their lifespan. Nonetheless, the fact that Aspen is the sole manufacturer of the medicines raises competition concerns.[20]

222. The point to note about all these reports is that the excessive pricing was experienced by monopsony purchasers – the UK's NHS, Italy's AIPA and the Spanish National Health Service. There is no reason to think that the NHI fund will be immune to anti-competitive behaviour by pharmaceutical and other companies. The Competition Act can protect the NHI fund from this. The object of the Competition Act is to protect consumer welfare.

223. For the reasons given above the Competition Act should be applicable to health care providers and suppliers to the NHI fund. Section 3(5) of the NHI Bill should therefore be amended to read :

'The Competition Act (Act No 89 of 1998) is not applicable to the NHI fund.'

This said, if the Competition Act is to be amended as contemplated in the schedule to the bill then section 3(5) is completely unnecessary and should be deleted.

224. Section 33 of the bill contradicts the amendments to be made to the Medical Schemes Act in the schedule to the bill. It says that the Minister will decide when NHI has been fully implemented and when medical schemes may only offer complementary cover. The schedule contains amendments to the Medical Schemes Act that, when put into operation, will determine the date on which medical schemes may only offer complementary cover. There will be no room for the Minister to decide on the appropriate time in terms of section 33 if the amendments in the schedule are made to the Medical Schemes Act. BHF recommends that the proposed amendments to the Medical Schemes Act be deleted from the Bill. The Act has been under review since at least 2018 when the Minister published a Medical Schemes Amendment Bill for public comment. The Department of Health subsequently agreed to hold this bill in abeyance until the findings of the Health Market Inquiry (HMI) were finalised. Since this has happened very recently, the department can no go back to revising the Medical Schemes Amendment Bill, taking into account the

[20] https://www.competition.org.za/review/2017/12/20/excessive-pricing-in-the-global-pharmaceutical-industry

recommendations of the HMI. Any amendments to the Medical Schemes Act should be made as a part of this process and should be separate from the NHI Bill.

225. BHF recommends that instead of the Minister appointing the pricing committee in consultation with the Office of Health Products Procurement, as proposed in the amendment of the Medicines Act in the schedule to the bill, he appoint the pricing committee in consultation with the board of the fund. The Office of Health Products Procurement is located within the fund and as such is subordinate to the board of the fund. It is simply a unit within the fund that sets parameters for the procurement of health products according to section 38.

Concluding Remarks

226. BHF welcomes this opportunity to comment on the NHI Bill. We note with concern that many of our comments when it was first published for public comment in 2018 seem to have been completely overlooked. Many of the comments we have made in the foregoing pages are with a view to the successful implementation of NHI and we hope that they will be taken in that light. It would be unfortunate if the implementation of NHI were to be delayed by a series of constitutional challenges to the bill or if the operationalisation of the Act were delayed by logistical problems and impracticalities.

227. We believe that the NHI fund can work if it is led by a fully accountable and responsible board appointed on the basis of its knowledge, skill and expertise. The integrity of this board is critical to the effective implementation of NHI. The fund, from its inception, must only be required to provide benefits to the extent that its resources allow. Health care is a bottomless pit that can never be completely satisfied. It is important to set boundaries for the liabilities of the fund right from the beginning so as to ensure that it never has an unfunded mandate. While it may eventually be able to fund the bulk of the health needs of beneficiaries, it will never be able to fund them all.

228. The fund must have the power to negotiate favourable terms with service providers, which means that the law of contract, rather than regulations made in terms of the NHI Act, must govern the relationship between the fund and providers. The NHI Act should

not be overly prescriptive in this area because the fund needs to be able to adapt to changing business conditions as well as changes in its operating environment. It must be able to cut its coat to suit its cloth. It must not be permitted to borrow money and must at all times have sufficient resources to fund its mandate. Too many state-owned enterprises have gotten themselves into trouble by borrowing money. The fund's liabilities must always be determined with regard to its available resources.

229. BHF believes that there should be a Prudential Authority that oversees the fund in terms of management of its financial risks and that Prudential Authority is the one located within the Reserve Bank in terms of the Financial Sector Regulation Act. We made mention of this in our previous comments on the NHI Bill to the Minister of Health but it apparently went unnoticed. It is crucial that the fund does not find itself in the same position as the Road Accident Fund – bankrupt and looking for bail-outs from the State.

230. The duty of the State to respect, protect, promote and fulfil the rights in the Bill of Rights, including the right of access to health care in section 27 of the Constitution, can never be fully transferred onto the fund because the fund is not the State. The constitutional duty of the State remains with the State, even once the fund is established. The State in our constitutional system includes all three spheres of government, not just national government.

231. The final report of the HMI was released recently. It contains a number of recommendations for supply side regulation that may be of benefit to the fund. The provider side of the purchaser/provider split is currently largely unregulated according to the HMI. BHF is not recommending that the supply side be regulated by the NHI Bill. There should be other legislation that does this. We are merely pointing out that the bill must be seen in the context of the larger legislative and policy framework within which it must operate. It will be necessary to amend a great deal of other legislation for the NHI system to function well.

232. BHF would be happy to address any questions arising from this submission either in writing or orally at the request of the committee.

PROPOSED AMENDMENTS TO THE NATIONAL HEALTH INSURANCE BILL

BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA

This document must be read in conjunction with BHF's detailed written comments on the bill above in order to fully understand why the changes proposed below are suggested.

Introduction

The BHF has prepared this document in order to assist the committee to better understand the nature of the amendments to the NHI Bill that are proposed in its written submission. Proposed changes to the wording of the bill are indicated in red below. In some cases, a brief explanatory note has been inserted after the proposed changes for the sake of clarity. However, for a full explanation for the proposed changes it is necessary to read BHF's written submission.

Some of the changes relate to the wording but other changes are proposed in order to ensure that the systems to be created by the bill are effective and efficient and that the Constitution is upheld.

BHF is of the view that the NHI fund must be accountable at three different levels in order to ensure its sustainability and viability. Firstly, the fund must be accountable to Parliament at a macro level, secondly the fund must be accountable to the Minister of Health in accordance with the Public Finance Management Act and thirdly the fund must be accountable to the Prudential Authority for financial institutions created by the Financial Institutions Regulation Act that sits within the Reserve Bank. The Prudential Authority should serve as an overseer of the fund in order to ensure that its financial risks and affairs are conducted properly and in accordance with independently determined standards. The Public Finance Management Act, although it applies to the fund, only regulates certain aspects of the fund. There is a gap which we submit must be filled by the Prudential Authority. The latter has the skills and expertise to provide specific oversight of the fund's financial affairs.

BHF recommends that the term 'beneficiary' should be used throughout the bill to describe persons who are registered with the fund and entitled to benefits from it because the term 'user' already has a specific definition in the NHA as a person who utilises health care services. We suggest this in order to avoid confusion between these two Acts.

NATIONAL HEALTH INSURANCE BILL

Definitions

1. In this Act, unless the context indicates otherwise -

~~**"Accredited"** means to be in possession of a valid certificate of accreditation from the fund as issued in terms of section 39;~~ **(Accreditation by the fund is unnecessary in light of the certification requirements in the bill. As long as a provider is certified by the OHSC it should not also have to be accredited by the fund as this will be a costly, resource-intensive and time-consuming process. The fund should formulate criteria that providers must meet in order for it to be able to contract with them. The fund must use the contracting process to determine whether or not it will contract with a particular provider based on whether or not he meets its criteria. Therefore, a separate accreditation process is unnecessary)**

"Ambulance services" means ambulance services as contemplated in part a of schedule 5 to the Constitution;

"Appeal tribunal" means the appeal tribunal established by section 44;

"Asylum seeker" has the meaning ascribed to it in section 1 of the Refugees Act;

"Beneficiary" means a person who has enrolled with the fund in terms of section 5 and is entitled to receive benefits from the fund; **(Note: It is recommended that in order to avoid confusion, the term 'beneficiary' be used instead of 'user' because the NHA already defines and uses the term 'user' as something different.)**

"Benefits Advisory Committee" means the Benefits Advisory Committee established in terms of section 25;

"Board" means the board of the fund established by section 12;

"Central hospital" means a public hospital designated as such by the Minister as a national resource to provide health care services to all residents, irrespective of the province in which they are located, and that must serve as a centre of excellence for conducting research and training of health workers;

"Certified", in respect of a health establishment, means to be in possession of a valid certificate issued by the OHSC as provided for in the NHA;

"Chief executive officer" means the person appointed in terms of section 19;

"Child" means a person ~~under the age of 18 years as~~ defined as such in section 28(3) of the Constitution;

~~**"Complementary cover"** means third party payment for personal health care service benefits not reimbursed by the fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund;~~ ~~**"comprehensive health care services"** means health care services that are managed so as to ensure a continuum of health promotion, disease prevention, diagnosis, treatment, management, rehabilitation and palliative care at services across the different levels and sites of care within the health system in accordance with the needs of users;~~ **('Comprehensive' may create unrealistic expectations as used in policy documents and by politicians. Section 27 of the constitution recognises that resources are finite and that benefits or services rendered must be based on available resources.)**

"Constitution" means the Constitution of the Republic of South Africa, 1996;

~~**"Contracting Unit for Primary Health Care"** means a Contracting Unit for Primary Health Care referred to in section 37;~~ **(Note: BHF has explained in its main submission that it is not appropriate either constitutionally, administratively or financially to create these structures.)**

"Department" means the National Department of Health established in terms of the Public Service Act, 1994 (Proclamation No. 103 of 1994);

~~**"District Health Management Office"** means a District Health Management Office referred to in section 36;~~ **(Note: BHF has explained in its main submission that it is not appropriate either constitutionally, administratively or financially to create these structures.)**

"Emergency medical services" means the health care services that are immediately necessary to prevent a temporary or permanent impairment of bodily function or imminent death, and include the urgent, specialised transportation of a beneficiary by ambulance or other specially equipped emergency vehicle to a public or private health establishment for further medical treatment ~~provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured~~;

"Financial year" means a financial year as defined in section 1 of the Public Finance Management Act;

"Formulary" means the Formulary ~~and its composition~~ referred to in section 38(4);

"Fund" means the National Health Insurance fund established by section 9;

"Health care service" means:

(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;

(b) ~~basic nutrition and~~ basic health care services contemplated in section 28(1)*(c)* of the Constitution;

(c) medical treatment contemplated in section 35(2)*(e)* of the Constitution; ~~and~~

~~*(d)* where applicable, provincial, district and municipal health care services;~~

"Health care service provider" means a natural or juristic person in the public or private sector providing health care services in terms of any law;

"Health establishment" means a health establishment as defined in section 1 of the NHA;

"Health goods", ~~in respect of the delivery of health care services~~, includes medical equipment, medicines, medical devices and supplies, or health technology ~~or health research~~ intended for use or consumption by, application to, or for the promotion, preservation, diagnosis or improvement of the health status of, a human being;

~~**"Health related product"** means any commodity other than orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance which is produced by human effort or some mechanical, chemical, electrical or other human engineering process for medicinal purposes or other preventive, curative, therapeutic or diagnostic purposes in connection with human health~~; **(Note: BHF has already explained in its main submission that this term is unnecessary and will simply cause confusion. The term 'health goods', defined as amended above, is sufficient.)**

"Health research" means health research as defined in section 1 of the NHA;

"Hospital" means a health establishment which is classified as a hospital by the Minister in terms of section 35 of the NHA or is registered as a hospital in terms of any law;

"Immigration Act" means the Immigration Act (Act No. 13 of 2002);

"Mandatory prepayment" means compulsory payment for health services before they are needed, in accordance with income levels;

'Medical device' bears the meaning ascribed to it in section 1 of the Medicines and Related Substances Act (Act No. 101 of 1965);

"medical scheme" means a medical scheme as defined in the Medical Schemes Act;

"Medical Schemes Act" means the Medical Schemes Act, 1998 (Act No. 131 of 1998);

"Medicine" means medicine as defined in section 1 of the Medicines and Related Substances Act (Act No. 101 of 1965)

"Minister" means the Cabinet member responsible for health;

"NHA" means the National Health Act (Act No. 61 of 2003);

"National health system" has the meaning ascribed to it in section 1 of the NHA;

"Office of Health Standards Compliance" means the Office of Health Standards Compliance established by section 77 of the NHA;

"Permanent resident" means a person having permanent residence status in terms of the Immigration Act;

"Personal information" means personal information as defined in section 1 of the Promotion of Access to Information Act;

~~**"Pooling of funds"** means the aggregation of financial resources for the purpose of spreading the risk across the population so that individual users can access health services without financial risk;~~

"Prescribed" means prescribed by regulation made under section 52~~5~~;

"Primary health care" means ~~addressing the main health problems in the community through providing promotive, preventive, curative and rehabilitative services and~~

(a) health care at the first level of contact of an individual ~~the family and community~~ with the national health system where he or she ~~bringing health care as close as possible to where people~~ lives ~~and~~ or works, and constitutes the first element of ~~a continuing~~ the health care process; and

(b) is the clinic in the public health sector and, in the private health sector, the general medical practitioner, or primary care nursing professional, primary care dental professional, physiotherapist, audiologist, speech therapist, optometrist, pharmacist, ~~and~~ primary allied health professional, or other health professional with whom a beneficiary can consult without the need for a referral ~~through multi-disciplinary practices~~;

"Procurement" has the meaning ascribed to it in section 217(1) of the Constitution;

"Promotion of Access to Information Act" means the Promotion of Access to Information Act (Act No. 2 of 2000);

'Protection of Personal Information Act' means the Protection of Personal Information Act (Act No 4 of 2013);

"Provider payment" means the payment of money to health care service providers ~~in a way that creates appropriate incentives for efficiency in the provision of quality and accessible health care services using a uniform reimbursement strategy~~ from whom the fund is purchasing health care services on behalf of beneficiaries;

"Prudential Authority" means the authority established in terms of section 32 of the Financial Sector Regulation, 2018 (Act No 9 of 2017)

"Public entity" means a national public entity as reflected in schedule 3 of the Public Finance Management Act;

"Public Finance Management Act" means the Public Finance Management Act (Act No. 1 of 1999);

"Referral" means the directing ~~transfer~~ of a beneficiary ~~user~~ to an appropriate health establishment ~~in terms of section 44(2) of the NHA~~ suitable for his or her health needs;

"Refugee" has the meaning ascribed to it in section 1 of the Refugees Act;

"Refugees Act" means the Refugees Act (Act No. 130 of 1998);

"Republic" means the Republic of South Africa;

~~"Social solidarity" means providing financial risk pooling to enable cross- subsidisation between the young and the old, the rich and the poor and the healthy and the sick;~~ **(Note: This term is not meaningful in law. It is a policy statement.)**

~~"Strategic purchasing" means the active purchasing of health care services by the pooling of funds and the purchasing of comprehensive health care services from accredited and contracted providers on behalf of the population; (~~**Note: 'Strategic purchasing' is a policy term that has no real meaning in law. In law the fund simply purchases health care goods and services. How it does that should be up to the fund).**

"This Act" includes any regulation promulgated~~, directive or rule made or notice issued~~ by the Minister in terms of this Act.~~; and~~

~~"User" means a person registered as a user in terms of section 5.~~

Purpose of Act

2. The purpose of this Act is to establish and maintain a National Health Insurance fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by:

(a) serving as the ~~single~~ national purchaser and ~~single~~ national payer of health care services in order to ensure the equitable and fair distribution and use of health care services;

(b) ensuring the sustainability of funding for health care services within the Republic; and

(c) providing for equity and efficiency in funding of health care services by the pooling of funds and the ~~strategic~~ centralised purchasing of health care services, medicines, health goods and health-related products from ~~accredited and~~ contracted health care service providers.

Application of Act

3. (1) This Act applies to all health establishments, excluding military health services and establishments.

(2) This Act does not apply to members of:

(a) the National Defence Force; and

(b) the State Security Agency.

(3) If any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law, except the Constitution and the Public Finance Management Act or any Act expressly amending this Act, the provisions of this Act prevail.

(4) The Act does not in any way amend, change or affect the funding and functions of any organs of state in respect of health care services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislation have been enacted or amended.

~~(5) The Competition Act, 1998 (Act No. 89 of 1998), is not applicable to any transactions concluded in terms of this Act.~~ **(Note: Only the NHI fund should be exempt from the Competition Act. Heath care providers and suppliers should be subject to the Competition Act because they should not be allowed to engage in anti-competitive practices in relation to the fund. The proposed amendment in the schedule of the bill to the Competition Act achieves this.)**

Population coverage

4. (1) The fund~~, in consultation with the Minister,~~ must purchase health care services, taking into account the recommendations by the Benefits Advisory Committee, on behalf of—

(a) South African citizens;

(b) Permanent residents;

(c) Refugees;

(d) Inmates as provided for in section 12 of the Correctional Services Act, 1998 (Act No. 111 of 1998); and

(e) Certain categories or individual foreigners determined by the Minister of Home Affairs, after consultation with the Minister and the Minister of Finance, by notice in the *Gazette*.

(2) An asylum seeker or illegal foreigner is only entitled to—

(a) emergency medical services; and

(b) health care services for notifiable conditions of public health concern.

(3) All children, including children of asylum seekers or illegal migrants, are entitled to basic health care services as provided for in section 28(1)*(c)* of the Constitution.

(4) A person seeking health care services purchased by the fund from a~~n accredited~~ contracted health care service provider or health establishment must be registered as a beneficiary ~~user~~ of the fund as provided for in section 5, and must present proof of such registration to the health care service provider or health establishment in order to secure the health care service benefits to which he or she is entitled.

Registration as beneficiaries ~~users~~

Section 5

(5) When applying for registration as a ~~user~~ beneficiary, the person concerned must provide his or her biometrics and other such information as may be prescribed, including fingerprints, photographs, proof of habitual place of residence and:

(a) an identity card as defined in the Identification Act (Act No. 68 of 50 1997); or

(b) ~~an original birth certificate~~ other recognised means of identification issued by the National Department of Home Affairs; or

(c) a refugee identity card issued in terms of the Refugees Act.

(7) ~~Unaccredited health establishments whose particulars are published by the Minister in the *Gazette*~~ The fund must~~, on behalf of the fund~~, register beneficiaries and maintain a register of all ~~users~~ these beneficiaries containing such details as may be prescribed.

~~(8) A user seeking health care services purchased for his or her benefit by the fund from an accredited health care service provider or health establishment must present proof of registration to that health care service provider or health establishment when seeking those health care services.~~
(**NOTE: Unnecessary repetition of section 4(4).)**

Rights of Beneficiaries~~users~~

6. Without derogating from any other right or entitlement granted under this Act or under any other law, a ~~user~~ beneficiary ~~of health care services purchased by the fund~~ is entitled, within the ~~State's~~ fund's available ~~and appropriated~~ resources:

(a) to receive necessary and appropriate, quality health care services free at the point of care from a~~n accredited~~ contracted health care provider or health establishment upon proof of registration with the fund;

(b) to information relating to the fund and health care service benefits available to ~~users~~ beneficiaries;

~~*(c)* to access any information or records relating to his or her health kept by the fund, as provided for in the Promotion of Access to Information Act, in order to exercise or protect his or her rights;~~ (**NOTE: Unnecessary repetition of the provisions of PAIA. The Act does not need to be reinforced by the bill.)**

(d) not to be refused access to health care services ~~on unreasonable grounds~~;

(e) ~~not to be unfairly discriminated against as provided for in the Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No. 4 of 2000);~~ **(NOTE: Unnecessary repetition of the provisions of PEPUD Act. The Act does not need to be reinforced by the Bill.)**

(f) to access health care services within a reasonable time period that is determined in accordance with relevant and internationally recognised clinical protocols and treatment guidelines;

(g) to be treated with a professional standard of care;

(h) to make ~~reasonable~~ decisions about his or her health care; **(NOTE: A person has a right to make ANY decision concerning his or her health care, regardless of whether or not someone else thinks it's reasonable)**

(i) to submit a complaint to the fund in accordance with section 42 regarding—

(i) ~~poor~~ access to or quality of health care services purchased by the fund; or

(ii) fraud, misconduct, negligence, corruption or other abuses by a health care service provider, a health establishment, or a supplier or the fund;

(j) to ~~request~~ written reasons for decisions by the fund; **(NOTE: The beneficiary should not have to request written reasons. The fund must provide them as a matter of course)**

(k) to lodge an appeal against a decision by the fund in accordance with section 43;

(l) to institute proceedings for the judicial review of any decision of the appeal tribunal;

(m) to the protection of his or her rights to privacy and confidentiality, in accordance with the Constitution, the Protection of Personal Information Act, ~~2013 (Act No. 4 of 2013)~~, the

Promotion of Access to Information Act and the relevant provisions of the NHA., in so far as he or she must grant written approval for the disclosure of personal information in the possession of or accessible to the fund, unless

the information -

(i) is shared among health care service providers for the lawful purpose of serving the interests of users; or

(ii) is utilised by the fund for any other lawful purpose related or incidental to the functions of the fund; **(NOTE: The Promotion of Access to Information Act is constitutionally mandated legislation and its provisions must not be varied in the NHI Bill. The Protection of Personal Information Act protects a person's constitutional right to privacy by setting out how information must be processed. The NHI fund must follow the provisions of this Act in processing the information of beneficiaries and health care service providers. It should not be trying to reinvent the wheel as it does in paragraph (m) above)**

(n) to have access to information on the funding of health care services in the Republic; and

(o) to exercise his or her constitutional right to have access to health care services by purchasiing of health care services that are not covered by the fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, any other lawful private health insurance scheme or out-of-pocket payments, as the case may be.

Health care services coverage

7. (1) Subject to the provisions of this Act, the fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, for the benefit of users. (**NOTE: Needless repetition of section 4(1))**

(2)(1) Subject to subsection (4):

(a) a user beneficiary must receive the health care services that he or she is entitled to under this Act from a health care service provider or health establishment at which the user beneficiary hads registered for the purposes of receiving those health care services;

(b) should a user beneficiary be unable to access the health care service provider or health establishment with whom or at which the user beneficiary is registered in terms of section 5,

~~such portability of~~ the beneficiary may access health care services ~~as may be prescribed must be available to that user~~ from a different health care service provider or health establishment in the prescribed manner;

(c) should a health care service provider or health establishment contemplated in 5 paragraph *(a)* or *(b)* not be able to provide the necessary health care services, the health care service provider or health establishment in question must ~~transfer~~ refer the ~~user~~ beneficiary concerned to another appropriate health care service provider or health establishment that is capable of providing the necessary health care services in such manner and on such terms as may be prescribed;

(d) a ~~user~~beneficiary:

(i) must first access health care services at a primary health care level as the point of entry into the health system;

(ii) must adhere to the referral pathways prescribed for health care service providers or health establishments; and

(iii) is not entitled to health care services purchased by the fund if he or she fails to adhere to the prescribed referral pathways;

(e) the fund must enter into contracts with ~~accredited~~ certified health care service providers and health establishments ~~at primary health care and hospital level~~ based on the health needs of ~~users~~ beneficiaries and in accordance with referral pathways.~~; and~~

~~*(f)* in order to ensure the seamless provision of health care services at the hospital level -~~

~~(i) the Minister must, by regulation, designate central hospitals as national government components in accordance with section 7(5) of the Public 25 Service Act, 1994 (Proclamation No. 103 of 1994);~~

~~(ii) the administration, management, budgeting and governance of central hospitals must be made a competence of national government;~~

~~(iii) the management of central hospitals must be semi-autonomous with certain decision-making powers, including control over financial management, human resource management, minor infrastructure, technology, planning and full revenue retention delegated by the national government; and~~

(iv) central hospitals must establish cost centres responsible for managing business activities and determine the cost drivers at the level where the activities are directed and controlled (**NOTE: This belongs in the NHA and not the NHI Bill. It involves the structuring of the health service delivery system, not the financing of health care)**

(4) Treatment must not be funded if - if a health care service provider demonstrates that – (**NOTE: Why should a health care provider have to 'demonstrate' that the service is not a medical necessity or that a health technology assessment exists or that the treatment is not included in the Formulary? To whom must he demonstrate this?)**

(*a*) in the considered professional opinion of a health care provider, no medical necessity exists for the health care service in question;

(*b*) a health technology assessment has determined that no cost-effective intervention exists for the health condition concerned care service as determined by a health technology assessment; or

(*c*) the health care product goods or treatment health care service are not included in the Formulary., except in circumstances where a complementary list has been approved by the Minister. (**NOTE: The Minister should not have the power to vary the Formulary as he sees fit from one day to the next.)**

Cost coverage

8. (1) A user of the fund is entitled to receive the health care services purchased on his or her behalf by the fund from an accredited health care service provider or health establishment free at the point of care. **(Unnecessary repetition of section 6(a))**

(2) (1) A person or user, beneficiary as the case may be, must may pay for health care services rendered directly, through a voluntary medical insurance scheme or through any other private insurance scheme or with his or her own resources, if that person or user beneficiary -

(*a*) is not entitled to a particular health care services purchased by the fund in terms of the provisions of this Act; or

(*b*) fails to comply with referral pathways prescribed by a health care service provider or health establishment; or

(c) seeks services that are not deemed medically necessary by the health care service provider with whom the beneficiary is registered as contemplated in section 5(1)~~the Benefits Advisory Committee~~; or

(d) seeks treatment that is not included in the Formulary~~.~~; or

(e) wishes to obtain a health care service or health goods from a health care service provider or supplier who is not contracted to the fund; or

(f) wishes to access health care services or health goods privately through a medical scheme or from his or her own pocket rather than through the fund.

(NOTE: A beneficiary should not be prevented from accessing health care services that are covered by the fund where the provider he wishes to use is not contracted by the fund. Similarly a person has a constitutional right to purchase health care goods and services from his own personal resources).

Establishment of fund

9. The National Health Insurance fund is hereby established as ~~an autonomous public entity~~ a juristic person and a national public entity, ~~as contained~~ listed in schedule 3A of the Public Finance Management Act. **(NOTE: The fund must expressly be given juristic personality)**

Functions of fund

10. (1) ~~To achieve the purpose of this Act, T~~The fund must:

(a)take all reasonably necessary steps to achieve the ~~objectives of the fund~~ purpose of the Act ~~and the attainment of universal health coverage~~ as outlined in section 2;

(b) pool ~~the allocated~~ its resources ~~in order to actively~~ into a single fund for the benefit of beneficiaries;

(c) ~~purchase and~~ procure health care services~~-medicines,~~ and health goods ~~and health related products~~ from contracted health care service providers, health establishments and suppliers ~~that are certified, and accredited~~ in accordance with the provisions of this Act, the NHA and the Public Finance Management Act;

~~(c)~~ (d) purchase health care services on behalf of ~~users~~ beneficiaries ~~as advised~~ taking into account the advice of the Benefits Advisory Committee;

~~(d)~~(e) enter into contracts with ~~accredited~~ certified health care service providers based on the health ~~care~~ needs of ~~users~~ beneficiaries and the quality standards expected of health care service providers, health establishments and suppliers;

~~(e)~~(f) prioritise the timely reimbursement of health care services ~~to achieve equity~~; **(NOTE: The deleted words are meaningless)**

~~(f)~~(g) establish mechanisms and issue directives for the regular, appropriate and timeous payment of health care service providers, health establishments and suppliers;

~~(g)~~(h) determine payment rates annually for health care service providers, health establishments and suppliers in the prescribed manner and in accordance with the provisions of this Act;

~~(h)~~(i) take measures to ensure that the funding of health care services is appropriate, efficient, effective and consistent with-health care quality standards, the level at which health care service providers render health care services to beneficiaries, and the nature, scope and extent of health care services required by beneficiaries. ~~the concepts of primary, secondary, tertiary and quaternary levels of health care services;~~

~~(i)~~(j) collect and collate health care service utilisation data and create and maintain its own ~~implement~~ information management systems to assist in monitoring the quality and standard of health care services~~,~~ and ~~medicines,~~health goods ~~and health related products~~ purchased by the fund;

~~(j)~~(k) develop and maintain a service and performance profile of all ~~accredited and~~ contracted health care service providers, health establishments and suppliers;

~~(k)~~(l) ensure that contracted health care service providers, health establishments and suppliers are paid in accordance with the quality and value of the health care services provided at ~~every~~ each level of care;

~~(l)~~(m) monitor the registration~~,~~ and licensce ~~or accreditation~~ status, as the case may be, of contracted health care service providers, health establishments and suppliers;

~~(m)~~(n) account to the-Minister in terms of the PFMA and to the Prudential Authority for regulatory oversight ~~on the performance of its functions~~ in respect of the safety and soundness, the financial risks and the financial stability of the fund-. ~~and the exercise of its~~

powers; (**NOTE: The fund should be accountable to an oversight body that has financial expertise and risk management and assessment expertise. The Prudential Authority which sits in the Reserve Bank is uniquely placed for this purpose as it regulates other financial institutions. There are three lines of accountability, namely to Parliament, the Minister in terms of the PFMA and Prudential Authority for oversight).**

(n)(o) undertake internal audit and risk management;

(o)(p) undertake research, monitoring and evaluation on various matters of relevance to the fund, including but not limited to of the impact of the fund on national health outcomes, health care benefit design, health care funding, financial management, risk management, fraud, waste and abuse involving health care resources, health outcomes for beneficiaries, the pricing and purchasing of health care services and health goods internationally, the financial performance of the fund and actuarial and economic forecasts and modelling;

(p)(q) liaise and exchange information with the Department, statutory health professional councils, the Council for Medical Schemes, other government departments and organs of state, and academic institutions for research purposes, as and when appropriate or necessary in order to achieve the purpose of the Act outlined set out in section 2;

(q)(r) maintain a national database on the demographic and epidemiological profile of the population beneficiaries;

(r)(s) protect the rights and interests of users beneficiaries of the fund;

(s)(t) enforce compliance with this Act;

(t)(u) take any other action or steps which are incidental to the performance of the functions or the exercise of the powers of the fund; and

(u)(v) operate in accordance with the provisions of this Act and other applicable law at all times.

(2) The fund must perform its functions in the most cost-effective and efficient manner possible and in accordance with the values and principles mentioned contemplated in section 195 of the Constitution and the provisions of the Public Finance Management Act.

(3) When the fund performs its functions it must take in accordance with national health policiesy into account approved by the Minister. **(NOTE: Policy is not law. The fund cannot**

therefore be bound by it. The Minister cannot make law in the form of policy. It is the role of Cabinet in terms of section 85(2)(d) of the Constitution, to develop and implement national policy. The fund must take it into account but cannot be bound by it as only law is binding.)

~~(4) The fund must support the Minister in fulfilling his or her obligation to protect, promote, improve and maintain the health of the population as provided for in section 3 of the NHA.~~ **(Note:-This is unnecessary and inappropriate. Do not transfer the Minister's obligations under the NHA to the fund.**

Powers of fund

11. (1) In order to achieve the purpose of the Act and to perform the functions outlined in section 10, the fund: ~~may—~~

(a) may employ personnel ~~and must comply with all applicable labour laws~~ (**NOTE: This goes without saying. The fund is bound by the labour laws by virtue of the labour laws themselves)**;

(b) may purchase or otherwise acquire goods, equipment, land, buildings, and any other kind of movable and immovable property;

(c) may sell, lease, mortgage, encumber, dispose of, exchange, cultivate, develop, build upon or improve, or in any other manner manage, its property;

(d) may in the prescribed manner and subject to national legislation, invest any money not immediately required for the conduct of its business and realise, alter or reinvest such investments or otherwise manage such funds or investments;

(e) may draw, draft, accept, endorse, discount, sign and issue promissory notes, bills and other negotiable or transferable instruments, excluding share certificates;

(f) may insure itself against any loss, or damage~~,~~ ~~risk or liability~~ which it may suffer or incur; **(Note: The fund should not be able to transfer its risks and liabilities for the funding of health care to any insurance company)**

~~*(g)* improve access to, and the funding, purchasing and procurement of, health care services, medicines, health goods and health related products that are of a reasonable quality(~~**Note: This is a function that is covered in section 10. It is not a power)**

(h) must investigate complaints against the fund, health care service providers, health establishments or suppliers;

(i) must identify, develop, promote and facilitate the implementation of best practices in respect of:

(i) the purchase of health care services and procurement of ~~medicines,~~ health goods ~~and health related products~~ on behalf of ~~users~~ beneficiaries;

(ii) payment of health care service providers, ~~health workers,~~ health establishments and suppliers **(Note: Health workers are employees of the State)**;

(iii) facilitation of the efficient and equitable delivery of quality health care services to ~~users~~ beneficiaries;

(iv) receiving and collating all required data from health care service providers, health establishments and suppliers for the efficient running of the fund;

(v) managing the risks ~~that~~ of the fund ~~is likely to encounter~~;

(vi) fraud, waste and corruption prevention within the fund and within the national health system;

(vii) the design of the health care service benefits to be purchased by the fund~~, in consultation with the Minister~~; and

(viii) referral networks ~~in respect of users, in consultation with the Minister~~;

(j) may undertake or sponsor health research and appropriate programmes or projects designed to facilitate ~~universal~~ access to health care services;

(k) must discourage and prevent corruption, fraud, unethical or unprofessional conduct ~~or~~ and abuse of ~~users~~ beneficiaries ~~or~~ and of the fund;

(l) may obtain from, or exchange information with, any other public entity, ~~or~~ organ of state or private entity;

(m) may conclude an agreement with any person for the performance of any particular act or particular work, or the rendering of health care services or the supply of health goods in terms of this Act, and may terminate such agreement where it has legal grounds for doing so

~~in accordance with the prescribed legal terms and conditions and the provisions of the Constitution~~;

(n) must not borrow any money from any other person or organ of state;

~~*(n)*~~ *(o)* may institute or defend legal proceedings and commence, conduct, defend or abandon legal proceedings as it deems fit in order to achieve its objects in accordance with this Act; and

~~*(o)*~~*(p)* may make recommendations to the Minister or advise him or her on any matter concerning the fund, including the making of regulations in terms of this Act.

(2) The fund may enter into a contract for the procurement and supply of specific health care services~~, and medicines,~~ health goods ~~and health related products~~ with a a~~n accredited~~ certified health care service provider, health establishment or supplier, and must—

(a) purchase such health care services and health goods ~~of~~ in sufficient quantity and of sufficient quality as to meet the health needs of ~~users~~ beneficiaries;

(b) take all reasonable measures to ensure that there ~~may be~~ is no interruption to the supply of health care services or health goods for the duration of the contract;

(c) conduct its business in a manner that is consistent with the best interests of ~~users~~ beneficiaries; and

~~*(d)* not conduct itself in a manner that contravenes this Act; and~~ **(Note: Unnecessary)**

(e) negotiate the ~~lowest possible~~ most reasonable price for goods and health care services, taking into account the need to ensure the sustainability of health care service providers, health establishments and suppliers of health goods, without compromising the interests of ~~users~~ beneficiaries or violating the provisions of this Act or any other applicable law.

Establishment of board

12. A board that is accountable to the Minister is hereby established to govern the fund in accordance with the provisions of the Public Finance Management Act and this Act.

Constitution and composition of board

13. (1) The board consists of not more than 11 persons appointed by Parliament ~~the Minister~~ who are not employed by the fund ~~and one member who represents the Minister~~. **(Note:**

According to the principles of corporate governance every member of a board must act in the best interests of his or her organisation, i.e. the fund. A member of the board who represents the Minister will have divided loyalties and will experience conflicts of interest. This is contrary to sound corporate governance)

(2) Before the board members contemplated in subsection (1) are appointed, ~~the Minister~~ Parliament must issue in the *Gazette* a call for the public nomination of candidates to serve on the board and must prepare a shortlist of candidates to be interviewed by the *ad hoc* committee contemplated in subsection (3) below.

(3) ~~An *ad hoc* advisory panel appointed by the Minister~~ Parliament must establish an *ad hoc* committee to:

(a) conduct public interviews with shortlisted candidates; ~~and~~

(b) recommend candidates for appointment to the board; and

~~*(b)*~~(c) forward the~~ir~~ committee's recommendations to ~~the Minister~~ Parliament for approval.

(4) The Minister must, within ~~30~~ 15 days from the date of confirmation of the appointment of a board member by Parliament, give notice of the appointment in the *Gazette*.

(5) A board member is appointed for a term not exceeding five years, which is renewable only once, and must:

(a) be a fit and proper person as prescribed; **(Note: The Minister must make regulations indicating what qualifies as fit and proper, otherwise this term is too vague)**

(b) have appropriate technical expertise, skills and knowledge or experience in corporate governance, ~~health care service~~ financ~~ing~~ial management, health economics, public health planning, health monitoring and evaluation, law, accounting, actuarial sciences, information technology or ~~and~~ communications management;

(c) be able to perform honestly and effectively and in the interests of beneficiaries and the fund ~~the general public~~;

(d) not be a director of, or employed by, an organisation operating within the health sector for the duration of his or her term of office;

~~*(d)*~~*(e)* not be employed by the State for the duration of his or her term of office; ~~and~~

~~(e)~~*(f)* not have any personal, financial or professional interest in ~~the fund or~~ the health sector that would interfere with the performance in good faith of his or her duties as a board member or that would result in an ongoing conflict of interest; and

(g) not be an official or an employee of any political party.

(6) If a person appointed to the board subsequently becomes employed by the State or an organisation operating in the health sector or a political party, or acquires a personal, financial or professional interest that conflicts with his or her performance of her or her fiduciary duties to the fund, that person is automatically disqualified from holding office as a member of the board.

~~(6)~~(7) The chief executive officer is an *ex officio* member of the board, but may not vote at its meetings.

~~(7)~~(8) A board member may resign by written notice to the Minister who must inform Parliament in writing within 15 days of such resignation.

~~(8)~~(9) ~~The Minister~~ Parliament ~~may~~ must remove a board member if that person:

(a) is or becomes disqualified to hold office in terms of any law or is prosecuted for an offence involving fraud, corruption, theft, forgery or any other crime involving dishonesty;

(b) fails to perform the functions of office in good faith, in the public interest and in accordance with applicable ethical and legal prescripts or recognised principles of sound corporate governance; or

(c) becomes unable to continue to perform the functions of office for any ~~other~~ reason.

~~(9)~~(10) *(a)* Subject to paragraph *(b)*, ~~the Minister~~ Parliament may dissolve the board on good cause shown only after:

(i) giving the board a reasonable opportunity to make representations; and

(ii) affording the board a hearing on any representations received.

(b) If ~~the Minister~~ Parliament dissolves the board in terms of this subsection, ~~the Minister~~ Parliament:

(i) may appoint acting board members for a maximum period of three months to do anything required by this Act, subject to any conditions that ~~the Minister~~ Parliament may require; and

(ii) must, as soon as is feasible, but not later than three months after the dissolution of the board, replace the board members in the same manner that they were appointed in terms of this section.

Chairperson and deputy chairperson

14. (1) The ~~Minister~~ board must ~~appoint~~ elect a chairperson from among its members as contemplated in section 13(1). **(Note: The Minister must not be able to appoint a chairperson of the board because the board must function independently of the Minister. The chairperson must not have loyalties to the Minister)**

(2) The board must ~~appoint~~ elect a deputy chairperson from among its members as contemplated in section 13(1).

(3) Whenever the chairperson and deputy chairperson of the board are absent or unable to fulfil their functions, the members of the board must designate any other member to act as chairperson during such absence or incapacity.

Functions and powers of board

15. (1) The board must fulfil the functions of an accounting authority as required by the Public Finance Management Act and is accountable to the Minister.

(2) The entire board as appointed in terms of section 13 ~~and 14~~ must meet at least ~~four~~ six times per year, excluding any special meetings and sub-committee meetings that may be called from time to time as is necessary.

(3) The board must govern the affairs and operations of the fund in accordance with recognised principles of sound corporate governance and may advise the Minister on any matter concerning:

(a) the management and administration of the fund, including operational, financial and administrative policies and practices;

(b) the development of ~~comprehensive~~ health care services to be funded by the fund ~~through~~ as advised by the Benefits Advisory Committee;

(c) the pricing of health care services to be purchased by the fund ~~through~~ as advised by the Health Care ~~Benefits~~ Services Pricing Committee of the board; **(Note: This committee will be advising the fund on what it must pay providers for health care services, not the benefits that the fund must provide to members)**

(d) the improvement of efficiency and performance of the fund in terms of ~~strategic~~ purchasing and provision of health care services;

~~*(e)* terms and conditions of employment of fund employees;~~ **(Note: Unnecessary)**

~~*(f)* collective bargaining;~~**(Note: Unnecessary)**

(g) the budget of the fund;

(h) the implementation of this Act and other relevant legislation; and

(i) overseeing the transition from when this legislation is enacted until ~~the fund~~ it is fully implemented.

(4) For the purposes of subsection (1), the board:

(a) may issue instructions or directives to the chief executive officer and may examine and comment on any policies, and investigate, evaluate and advise on any practices and decisions of the fund or the chief executive officer under this Act;

(b) is entitled to all relevant information concerning the finances, management and administration of the fund and any other information necessary for the board to effectively and efficiently govern the fund;

(c) may require:

(i) the chief executive officer to submit a report concerning any matter on which the board requires information in order to effectively carry out its duties, fulfil its functions or exercise its powers in terms of this Act ~~must give advice~~; or

(ii) any fund employee to appear before it and give explanations concerning ~~such a~~ any matter~~;~~. ~~and~~

~~*(d)* must inform the Minister of any advice it gives to the Chief Executive Officer.~~ **(Note: This is inappropriate. The Minister must not be able to influence the relationship between the board and the CEO)**

Conduct and disclosure of interests

16. (1) A member of the board may not engage in any paid employment that may conflict with the proper performance of his or her functions.

(2) A member of the board ~~may~~ must not:

(a) be a government employee or an employee of the fund or an employee or official of a political party;

(b) may not be a director, owner, employee, partner, agent or officer of a company or other organisation with which the fund has contracted or may contract;

~~*(b)*~~*(c)* attend, participate in, vote at or influence the proceedings of ~~during~~ a meeting of the board or a board committee, if that member has an interest, including a financial interest, that precludes him or her from acting in a fair, unbiased and proper manner; or

~~*(c)*~~*(d)* make private use of, or profit from, any ~~confidential~~ information obtained as a result of performing his or her functions as a member of the board.

(3) For purposes of subsection (2)~~*(b)*~~*(c)* a financial interest means a direct or indirect material interest of a monetary nature, or to which a monetary value may be attributed.

(4) Every member of the board must:

(a) act with good faith, due care, skill and diligence in executing the work of the board;

(b) conduct himself or herself in a manner that promotes and maintains the integrity of the board at all times;

(c) avoid conflicts of interest; and

(d) act independently and free from bias in his or her role as a member of the board.

Procedures

17. The board must determine its own procedures ~~in consultation with the Minister~~. **(Note: This is unnecessary and inappropriate. The Minister is not a member of the board and he should not be micro-regulating it at this level. The board needs to have a certain degree of flexibility in setting its procedures and should not have to ask the Minister's permission before making a change to its procedures.)**

Remuneration and reimbursement

18. The fund may remunerate a board member, and compensate him or her for expenses, as determined by the Minister in consultation with the Minister of Finance ~~and in line~~ in accordance with the provisions of the Public Finance Management Act.

Appointment

19. (1) A chief executive officer must be appointed on the basis of his or her experience, professional skill and technical competence as the executive ~~administrative~~ head of the fund in accordance with an open, transparent and competitive process.

(2) The board must:

(a) conduct interviews of shortlisted candidates; and

(b) ~~forward their recommendations to the Minister for approval by Cabinet~~ appoint the candidate who has the necessary qualifications, skill, experience and technical competence and is most suitable as Chief Executive Officer. **(Note: The CEO must not have divided loyalties. His or her loyalties must lie with the board and the fund only, not to the Minister or Cabinet. The CEO must not be a political appointment, which he/she would be if the Minister or Cabinet appointed him/her. The principles of sound corporate governance dictate that the CEO must be accountable only to the board and only the board must be able to hire and fire the CEO.**

(3) The ~~Minister~~ board must, within 30 days from the date of appointment of the chief executive officer, notify the Minister and Parliament of the ~~final~~ appointment and give notice of the appointment in the *Gazette*.

(4) A person appointed as chief executive officer holds office:

(a) for an agreed term not exceeding five years, which is renewable only once; and

(b) subject to the directives and determinations of the board ~~in consultation with the Minister~~.

(5) The board may ~~recommend to the Minister the~~ removale ~~of~~ the chief executive officer from office if ~~that person~~ he or she:

(a) ~~is or~~ becomes disqualified for office in terms of ~~the~~ any law or is convicted of a criminal offence;

(b) fails to perform the functions of his or her office in good faith, in the public interest ~~and~~ or in accordance with applicable law ~~ethical and legal prescripts~~ or the fund's code of ethics; or

(c) becomes unable to ~~continue to~~ perform the functions of his or her office by virtue of mental or physical impairment or because he or she has been found guilty of misconduct by the board or because he or she has acted dishonestly or has used his or her position for personal gain.

Responsibilities

20. (1) The chief executive officer as ~~administrative~~ executive head of the fund:

(a) is directly accountable to the board;

(b) is responsible for the functions specifically designated by the board;

(c) takes all decisions as contemplated in terms of subsection (6); and

(d) must report to the board at each board meeting ~~on a quarterly basis~~ on matters involving the fund and to Parliament on an annual basis.

(2) Subject to the direction of the board, the responsibilities of the chief executive officer include the:

(a) formation and development of an efficient fund administration;

(b) organisation and control of the staff of the fund;

(c) maintenance of discipline within the fund;

(d) effective deployment and utilisation of staff to achieve maximum operational results; and

(e) establishment of an investigating unit within the national office of the fund for the purposes of:

(i) investigating complaints of fraud, corruption, other criminal activity, unethical business practices and abuse relating to any matter affecting the fund or ~~users~~ beneficiaries of the fund; and

(ii) liaising with the ~~District Health Management Office~~ heath care providers concerning any matter contemplated in subparagraph (i).

(3) Subject to the direction of the board, the chief executive officer must ensure ~~establish~~ that the following ~~units~~ functions are carried out within the fund to ensure its efficient and effective functioning:

(a) Financial planning;

(b) Benefit~~s~~ design;

~~*(c)* Provider Payment Mechanisms and Rates;~~

~~*(d)(c)* Accreditation;~~

~~*(e)*~~*(c)* Purchasing and contracting;

~~(f)~~(d) Provider payment;

~~(g)~~(e) Procurement;

~~(h)~~(f) Performance monitoring and evaluation; and

~~(i)~~(g) Risk and fraud prevention and investigation.

(4) Subject to the direction of the board, the chief executive officer is responsible for:

(a) all income and expenditure of the fund;

(b) all revenue received by the fund ~~from the National Treasury established by section 5 of the Public Finance Management Act or obtained from any other source, as the 20 case may be~~;

(c) the protection, management and maintenance of all assets of the fund and ensuring the discharge and management by the fund of ~~all~~ its liabilities ~~of the fund~~; and

(d) the proper and diligent implementation of financial management and controls ~~matters of~~ within the fund as provided for in the Public Finance Management Act.

(5) The chief executive officer must submit to the board an annual report of the activities of the fund during a financial year as outlined in section 51, which must include:

(a) details of the financial performance of the fund, as audited by the Auditor-General, including evidence of the proper and diligent implementation of the Public Finance Management Act;

(b) details of performance of the fund in relation to ensuring access to quality health care services ~~in line~~ consistent with the health care needs of beneficiaries ~~the population~~;

(c) the number of accredited and ~~approved~~ contracted health care providers; and

(d) the health status of ~~the population~~ beneficiaries based on such requirements as may be prescribed.

(6) The chief executive officer must perform the functions of his or her office with diligence and as required by this Act and all other relevant law.

Relationship of chief executive officer with Minister, Director-General and Office of Health Standards Compliance

21. (1) The chief executive officer of the fund must meet with the Minister, Director-General of Health and the chief executive officer of the Office of Health Standards Compliance at least four

times per year. ~~in order to exchange information necessary for him or her to carry out his or her responsibilities.~~

(2) Notwithstanding subsection (1) the chief executive officer remains accountable only to the board.

Staff at executive management level

22. The chief executive officer may not appoint or dismiss members of staff of the fund employed at executive management level without the prior written approval of the board.

Committees of board

23. (1) The board may establish a sub-committee and, subject to such conditions as it may impose, delegate or assign any of its powers or duties to a sub-committee so established.

(2) Each sub-committee established in terms of subsection (1) must have at least one board member appointed in term of section 13(1) as a member of that sub-committee.

(3) Sub-committees of the board as established in subsection (1) must meet at least ~~four~~ six times per year in order to report to the meeting of the full board and may convene special meetings to discuss urgent matters when necessary.

(4) The board may dissolve or reconstitute a sub-committee on good cause shown.

Technical committees

24. (1) *(a)* The board may establish as many technical committees as ~~may be~~ it deems necessary to achieve the purpose of this Act.

(b) The provisions of section 29 apply to paragraph *(a)* with the changes required by the context.

(2) A committee established in terms of subsection (1)*(a)* must perform its functions impartially and without fear, favour or prejudice.

(3) A person appointed as a member of such a committee must:

(a) be a fit and proper person as prescribed;

(b) have appropriate expertise or experience; and

(c) have the ability to perform effectively as a member of that committee.

(4) A member of such a committee must not:

(a~~)~~ ~~act in any way that is inconsistent with subsection (2) or~~ expose himself or herself to any situation in which the risk of a conflict between his or her official responsibilities and ~~private~~ personal interests may arise; or

(b) use his or her position, or any information entrusted to him or her, for self-enrichment or to improperly benefit any other person.

Benefits Advisory Committee

25. (1) The Minister must, ~~after~~ in consultation with the board and by notice in the *Gazette*, ~~establish~~ appoint a committee of not more than 13 persons to be known as the Benefits Advisory Committee, as ~~one of the~~ a standing advisory committee~~s~~ of the fund, 11 of whom are from a list of persons nominated by the public in writing at the invitation of the Minister by notice in the *Gazette*.

(2) The membership of the Benefits Advisory Committee~~, appointed by the Minister,~~ must consist of persons with technical expertise in medicine, pharmacy, benefit design, public health, health economics, health technology, epidemiology and ~~the rights of~~ patient rights. ~~and~~ One member must be employed at deputy director-general level by the Department and one member must be an employee of the fund. ~~represent the Minister~~.

(3) A person appointed in terms of subsection (2):

(a) serves for a term of not more than ~~five~~ four years and may be reappointed for one more term only; and

(b) must satisfy the prescribed fit and proper requirements at the time of his or her appointment;

~~(b)~~(c) ceases to be a member of the committee when he or she ~~is no longer a member of the institution that nominated him or her or when he or she resigns~~, dies, is physically or mentally impaired such that he or she is no longer able to fulfil the duties of office, ceases to satisfy the prescribed fit and proper requirements, or when he or she is found guilty by the board of misconduct in the execution of his or her duties as a member.

(4) A vacancy in the Benefits Advisory Committee must be filled by the appointment of a person for the unexpired portion of the term of office of the member in whose place the person is appointed, and in the same manner in which the member was appointed in terms of subsection (2).

(5) The Benefits Advisory Committee must make recommendations to the board regarding, determine and review on an annual basis:

(a) the health care service benefits and the types nature and extent of health care services and health goods to be reimbursed purchased by the fund at each level of care; at primary health care facilities and at district, regional and tertiary hospitals;

(b) detailed and cost-effective treatment guidelines with regard to health care services and the utilisation of health goods that take into account the emergence of new technologies in health care; and

(c) in consultation with the Minister and the board, the health care service benefits provided by the fund.

(6) The Minister must appoint the chairperson from among the members of the committee who are not employees of the Department or the fund.

(7) The Minister must, by notice in the *Gazette,* publish the guidelines contemplated in subsection (5)*(b)* and may prescribe assign additional functions to the Benefits Advisory Committee that are not inconsistent with this Act.

Health Care Benefits Services Pricing Committee (Note: This committee must advise the board on what it should be paying for health care services, not on the benefits that the fund must provide.)

26. (1) The Minister must, after in consultation with the board and by notice in the *Gazette*, establish a Health Care Benefits Services Pricing Committee as one of the a standing advisory committees of the fund, consisting of not less than 16 11 and not more than 24 13 members. **(Note: a committee of 16 to 24 members is too big to be effective and could become bogged down.)**

(2) The Health Care Benefits Services Pricing Committee must consists of persons with expertise in actuarial science, medicines, epidemiology, pharmacy, health management, health economics, health care financing, labour benefit design, the pricing of health care services or

health goods and the rights of patients, and one member must be an employee of the Department and one member must be an employee of the fund~~. represent the Minister~~.

(3) The committee must conduct research into the pricing of health care services and health goods and make recommendations to the fund on the prices of health services and health goods ~~benefits~~ that are ~~be~~ paid for by ~~to~~ the fund for the purpose of ensuring the most efficient and effective utilisation of the fund's resources.

(4) The Minister must appoint the chairperson from among the members of the Health Care Services Pricing Committee who are not employees of the Department or the fund.

(5) The members of the Health Care Services Pricing Committee who are not employees of the Department or the fund must be remunerated in the manner determined by the Minister in consultation with the Minister of Finance in accordance with the Public Finance Management Act and may serve on the committee for a period of no longer than eight years in total.

(6) Subject to subsection (2), the members of the Health Care Services Pricing Committee must not be employees of the government or directors, owners, officers, employees or agents of contractors to the fund.

(7) Members of the Health Care Services Pricing Committee must avoid conflicts of interest and must fulfil their duties in good faith and with due care, skill and diligence at all times.

(8) A member of the Health Care Services Pricing Committee must be a fit and proper person as prescribed and ceases to hold office if he or she-:

(a) dies, resigns by notice in writing to the Minister, or becomes mentally or physically impaired to the extent that he or she can no longer perform his or her duties;

(b) no longer satisfies the prescribed fit and proper requirements;

(b) is found guilty of misconduct by the board in the execution of his or her duties as a member;

(c) is convicted of the offence of fraud or corruption or any other crime involving dishonesty or is struck off the roll by his or her professional body for unprofessional conduct.

Stakeholder Advisory Committee

27. **(**1) The Minister must, after consultation with the board and by notice in the *Gazette*, appoint a Stakeholder Advisory Committee comprised of representatives nominated in writing by ~~from~~

the statutory health professions councils, public health institutions~~public entities~~, organised labour, employer organisations, ~~civil society~~ non-governmental organisations, associations of health ~~professionals,~~ care service providers and private hospitals, pharmaceutical representative organisations, organisations representing medical schemes, as well as patient advocacy groups in ~~such a~~ the prescribed manner ~~as may be prescribed~~.

(2) The Stakeholder Advisory Committee may make written and oral representations to the fund or the Minister on matters relating to health care financing, the nature and extent of health service benefits provided by the fund, access of beneficiaries to health care services, the manner in which complaints are dealt with by the fund, health benefit design, the pricing of health care services and health goods purchased by the fund, the payment by the fund of health care service providers and suppliers, and any other matter relevant to the operations of the fund.

(3) The Stakeholder Advisory Committee must meet at least twice a year and must furnish a written report on its findings and decisions at such meetings to the Minister and the board.

Disclosure of interests

28. A member of a committee established by the Minister in terms of this Act who has a personal or financial interest in any matter on which such committee gives advice or takes a decision, must disclose that interest when that matter is discussed, ~~and~~ must be recused during the discussion and is not allowed to vote on that matter.

Procedures and remuneration

29. When the Minister establish~~inges~~ a committee ~~under this Chapter~~ in terms of this Act, the Minister must determine by notice in the *Gazette*:

(a) its composition, functions and working procedures;

(b) in consultation with the Minister of Finance, the terms, conditions, remuneration and allowances applicable to its members; and

(c) any incidental matter relating to the committee.

Vacation of office

30. A member of a committee established in terms of this Act ceases to be a member if:

(a) that person resigns in writing to the board or the Minister, as the case may be ~~from that committee~~;

(b) the Minister or the board, as the case may be, terminates that person's membership for an adequate reason; or

(c) the term for which the member was appointed expires and ~~the membership~~ is not renewed.

~~**Role of Minister**~~

~~**31.** (1) Without derogating from any responsibilities and powers conferred on him or her by the Constitution, the NHA, this Act or any other applicable law, the Minister is responsible for—~~

1. ~~*(a)* governance and stewardship of the national health system; and~~
2. ~~*(b)* governance and stewardship of the fund in terms of the provisions of this Act.~~

~~(2) The Minister must clearly delineate in appropriate legislation the respective roles and responsibilities of the fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the NHA, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services.~~

(Note: This section is entirely unnecessary and does not belong in this legislation. The Minister's responsibilities and role are as the section states defined by the Constitution and the NHA. Section 31 is effectively meaningless as it does not impose any addition duties or grant any functions to the Minister that he does not already have in terms of other legislation.)

~~**Role of medical schemes**~~

~~**33.** Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the *Gazette*, medical schemes may only offer 35 complementary cover to services not reimbursable by the fund.~~ **(Note: This section is unconstitutional and should be deleted from the bill. It is also irrelevant to the NHI fund and should be dealt with during the review of the Medical Schemes Act that is currently taking place. For this reason also, the proposed amendments to the Medical Schemes Act in the schedule to this bill should be deleted.)**

National health information system

~~**34.**~~ **33** (1) The fund must contribute information ~~to the development and maintenance of~~ the national health information system ~~as~~ contemplated in section 74 of the NHA through the information platform established in terms of section 40.

(2) Subject to the provisions of the National Archives and Record Services of South Africa (Act No. 43 of 1996), the Protection of Personal Information Act (, the NHA (Act No. 61 of 2003) and the Promotion of Access to Information Act, ~~data~~ information must be accurate and accessible to the Department and the fund, or to any other person ~~stakeholder~~ legally entitled to such information.

~~(3) Health workers, health care service providers and persons in charge of health establishments must comply with the provisions in the NHA relating to access to health records and the protection of health records.~~ **(This section is completely unnecessary as the relevant provisions are already in the NHA.)**

Purchasing of health care services

~~35~~. 34 (1) The fund must ~~actively and strategically~~ purchase health care services on behalf of ~~users~~ beneficiaries ~~in accordance with~~ with reference to their health care needs.

(2) The fund must ~~transfer~~ pay funds to ~~accredited and~~ contracted ~~central, provincial, regional, specialised and district~~ hospitals in the public and the private sector in respect of health care services rendered by them and health goods supplied by them: provided that should a public hospital be owned by a provincial government or a municipality, the fund must pay the relevant provincial government department or municipality ~~based on a global budget or Diagnosis Related Groups~~.

~~(3) funds for primary health care services must be transferred to Contracting Units for Primary Health Care at the sub-district level as outlined in section 37.~~

(4)(3) *(a)* The fund may purchase emergency medical services from contracted providers of such services in the private sector. ~~Emergency medical services provided by accredited and contracted public and private health care service providers must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.~~ **(Note: This is too prescriptive and does not belong in legislation. The fund should not be restricted on how it pays for emergency medical services.**

(b) Public ambulance services must be funded by the provincial governments through their equitable share of revenue raised nationally, as contemplated in the Constitution. ~~reimbursed through the provincial equitable allocation~~.

~~Role of District Health Management Office~~

~~**36.** A District Health Management Office established as a national government component in terms of section 31A of the NHA must manage, facilitate, support and coordinate the provision of primary health care services for personal health care services and non-personal health services at district level in compliance with 10 national policy guidelines and relevant law.~~ **(Note: This section belongs in the NHA and not this bill. It has nothing to do with health financing)**

~~**Contracting Unit for Primary Health Care**~~

~~**37.** (1) A Contracting Unit for Primary Health Care established in terms of section 31B of the NHA—~~

~~*(a)* manages the provision of primary health care services, such as prevention, 15 promotion, curative, rehabilitative ambulatory, home-based care and community care in a demarcated geographical area; and~~

~~*(b)* is the preferred organisational unit with which the fund contracts for the provision of primary health care services within a specified geographical area.~~

~~(2) A Contracting Unit for Primary Health Care must be comprised of a district 20 hospital, clinics or community health centres and ward-based outreach teams and private providers organised in horizontal networks within a specified geographical sub-district area, and must assist the fund to—~~

~~*(a)* identify health care service needs in terms of the demographic and epidemiological profile of a particular sub-district; 25~~

~~*(b)* identify accredited public and private health care service providers at primary care facilities;~~

~~*(c)* manage contracts entered into with accredited health care service providers, health establishments and suppliers in the relevant sub-district in the prescribed manner and subject to the prescribed conditions; 30~~

~~*(d)* monitor the disbursement of funds to health care service providers, health establishments and suppliers within the sub-district;~~

~~*(e)* access information on the disease profile in a particular sub-district that would inform the design of the health care service benefits for that sub-district;~~

~~*(f)* improve access to health care services in a particular sub-district at 35 appropriate levels of care at health care facilities and in the community;~~

~~*(g)* ensure that the user referral system is functional, including the transportation of users between the different levels of care and between accredited public and private health care service providers and health establishments, if necessary;~~

~~*(h)* facilitate the integration of public and private health care services within the 40 sub-district; and~~

~~*(i)* resolve complaints from users in the sub-district in relation to the delivery of health care services.~~

(Note: This section has nothing to do with health financing or the fund and belongs in the NHA, if indeed it belongs anywhere.)

Office of Health Goods ~~Products~~ Procurement

3~~8~~ 35. (1) The board, ~~in consultation with the Minister,~~ must establish an Office of Health Goods ~~Products~~ Procurement which sets parameters for the ~~public~~ procurement by the fund of health goods ~~related products~~.

(2) The Office of Health ~~Products~~ Goods Procurement must be located within the fund and be responsible for the ~~centralised facilitation and coordination of functions related to the public~~ procurement of health goods that are part of the benefits provided by the fund. ~~related products, including but not limited to medicines~~, ~~50 medical devices and equipment~~.

(3) The Office of Health Goods ~~Products~~ Procurement must:

(a) determine the selection of health goods ~~related products~~ to be procured by the fund, health care providers and health establishments in accordance with the Formulary, taking into consideration the advice of the Benefits Advisory Committee and the Health Care Services Pricing Committee, in accordance with any directives issued by the board;

(b) develop a national health ~~products~~ goods list describing the nature and prices of health goods that may be procured and their uses with reference to the benefits provided by the fund;

(c) coordinate the supply chain management process and price negotiations for health goods ~~related products~~ contained in the list mentioned in paragraph *(b)*;

(d) regularly assess the needs of contracted health establishments and health care providers with regard to the quantity, quality and specifications of health goods required for the provision of benefits by the fund and identify and investigate undesirable business practices within the supply chain;

(e) ensure that contracted health establishments and health care service providers are engaging in efficient and effective stock control or asset management, as the case may be, in respect of health goods and, where applicable, that the appropriate and regular maintenance of medical devices and equipment is conducted according to the standards set by the manufacturer;

(e) establish procedures and mechanisms in the procurement process to prevent fraud, theft, corruption, counterfeiting or other criminal activity and immediately report in writing to the chief executive officer of the fund all instances of stock mismanagement, fraud, corruption or other criminal activity that come to its attention in the course of the fulfilment of its functions;

(f) facilitate the prompt and appropriate payment of suppliers of health goods in accordance with any applicable contractual provisions;

(f) submit an annual report to the board on procurement of health goods and the nature and extent of any losses experienced by the fund due to undesirable business practices and criminal activity relating to procurement.

(4) The Office of Health ~~Products~~ Goods Procurement must support the Benefits Advisory Committee in the development and maintenance of the Formulary, comprising the Essential Medicines List and Essential Equipment List as well as a list of health-related products used in the delivery of services ~~as approved by the Minister in consultation with the National Health Council and the fund~~.

(5) The Office of Health ~~Products~~ Goods Procurement must support the annual review of the Formulary ~~annually~~, or more regularly if required, to take into account changes in the burden of disease, product availability, price changes and disease management ~~for approval by the Minister~~.

(6) A contracted ~~n accredited~~ health care service provider ~~and~~ or health establishment must procure according to the Formulary, and suppliers listed in the Formulary must deliver directly to the a~~ccredited and~~ contracted health care service provider ~~and~~ or health establishment as the case may be.

(7) The provisions of this section are subject to public procurement laws and policies of the Republic that give effect to the provisions of section 217 of the Constitution, including the Preferential Procurement Policy Framework Act (Act No. 5 of 2000), and the Broad-Based Black Economic Empowerment Act (Act No. 53 of 2003).

~~Accreditation of service providers~~ (A formal accreditation process for providers is unnecessary. When contracting with a provider the fund must determine whether or not the provider meets the fund's criteria.)

~~39~~ 36. ~~(1) Health care service providers and health establishments accredited by the fund in terms of this section must deliver health care services at the appropriate level of care to users who are~~

~~in need and entitled to health care service benefits that have been purchased by the fund on their behalf.~~

~~(2) In order to be accredited by the fund, a health care service provider or health establishment, as the case may be, must—~~

~~*(a)* be in possession of and produce proof of certification by the Office of Health Standards Compliance and proof of registration by a recognised statutory health professional council, as the case may be; and~~

~~*(b)* be able to meet the needs of users and ensure service provider compliance with prescribed specific performance criteria, including the—~~

~~(i) provision of the minimum required range of personal health care services specified by the Minister in consultation with the fund and published in the *Gazette* from time to time as required;~~

~~(ii) allocation of the appropriate number and mix of health care professionals, in accordance with guidelines, to deliver the health care services specified by the Minister in consultation with the National Health Council and the fund, and published in the *Gazette* from time to time as required;~~

~~(iii) adherence to treatment protocols and guidelines, including those for prescribing medicines and procuring health products from the Formulary;~~

~~(iv) adherence to health care referral pathways;~~

~~(v) submission of information to the national health information system to ensure portability and continuity of health care services in the Republic and performance monitoring and evaluation; and~~

~~(vi) adherence to the national pricing regimen for services delivered.~~

(~~3~~1) The fund must conclude a legally binding contract with a health establishment or health care service provider certified by the Office of Health Standards Compliance ~~and with any other prescribed health care service provider that satisfies the requirements listed in subsection (2)~~ to provide:

(a) primary health care services ~~through Contracting Units for Primary Health Care~~;

(b) emergency medical services; and

(c) hospital services.

(~~4~~2) The contract between the fund and a~~n accredited~~ health care service provider or health establishment must contain a clear statement of performance expectation ~~and need~~ in respect of the ~~management~~ treatment of beneficiaries ~~patients~~, the volume and quality of health care services to be delivered and access to such services by beneficiaries.

(~~5~~3) In order to be contracted ~~accredited and~~ and reimbursed by the fund, a health care service provider or health establishment must agree to submit information to the fund for recording on the Health Patient Registration System, including:

(a) national identity number or permit and visa details issued by the Department of Home Affairs, as the case may be;

(b) diagnosis and procedure codes using the prescribed coding systems;

(c) details of treatment administered, including medicines dispensed and equipment used;

(d) diagnostic tests ordered;

(e) length of stay of an inpatient in a hospital facility;

(f) health care provider or health establishment ~~facility~~ to which a beneficiary ~~user~~ is referred, if applicable ~~relevant~~;

(g) reasons for non-provision or rationing of treatment, if any; and

(h) any other information prescribed ~~deemed necessary~~ by the Minister in consultation with the fund for the monitoring and evaluation of national health outcomes.

(~~6~~4) The performance of a~~n accredited~~ contracted health care service provider or health establishment must be monitored and evaluated in accordance with this Act and appropriate sanctions must be applied by the fund where there is deviation from contractual obligations. ~~as per the law~~.

(~~7~~5) The fund must renew the ~~accreditation~~ contracts of service providers every five years on the basis of compliance with the ~~accreditation~~ contracting criteria set by the fund ~~as reflected in subsection (2)~~.

(~~8~~6) The fund may ~~withdraw or~~ refuse to renew the contract ~~accreditation~~ of a health care service provider or health establishment if it is proven that the provider or establishment, as the case may be:

(a) has failed or is unable to deliver the required ~~comprehensive~~ health care service benefits to ~~users~~ beneficiaries entitled to them;

(b) is no longer in possession of, or is unable to produce proof of, certification by the Office of Health Standards Compliance ~~and~~ or proof of current registration by the relevant statutory health professions council, as the case may be;

~~*(c)* has failed or is unable to ensure the allocation of the appropriate number and mix of health care professionals to deliver the health care services specified in the *Gazette*;~~

(d) has failed or is unable to adhere to treatment protocols and guidelines, including prescribing medicines and procuring health goods ~~products~~ from the Formulary;

(e) has failed or is unable to comply with prescribed health care referral pathways;

(f) for any reason whatsoever, does not submit to the fund the information contemplated in section ~~34~~(~~3~~) 36(3) timeously;

~~*(g)* fails to adhere to the national pricing regimen for services delivered;~~

(h) intentionally ~~or negligently~~ breaches any substantive terms of a legally binding contract concluded with the fund;

(i) fails or is unable to perform as required by the terms of a legally binding contract concluded with the fund;

(j) delivers services of a quality not acceptable to the fund; or

(k) infringes any code of health-related ethics or relevant law applicable in the Republic.

(~~9~~7) If the fund ~~withdraws the accreditation~~ terminates a contract ~~of~~ with a health care service provider or health establishment, or refuses to renew ~~the accreditation~~ a contract, the fund must:

(a) provide the provider or establishment with notice of the decision;

(b) provide the provider or establishment with a reasonable opportunity to make representations in respect of such a decision;

(c) consider the representations made in respect of paragraph *(b)*; and

(d) provide adequate written reasons for the decision ~~to withdraw or refuse the renewal of accreditation~~ to the provider or establishment, as the case may be.

(~~10~~8) A health care service provider or health establishment who is dissatisfied with the reasons for the decision provided in terms of subsection (8)*(d)* may lodge an appeal in terms of section 43.

(~~11~~9) The fund may issue directives relating to the listing and publication of ~~accredited~~ contracted health care service providers and health establishments.

Information platform of fund

~~40~~ 37. (1) The fund must establish an information ~~platform~~ system to enable it to make informed decisions on ~~population~~ beneficiary health needs assessment, financing, purchasing, ~~patient~~ beneficiary registration with contracted health care service providers, service provider contracting and reimbursement, utilisation patterns, performance management, setting the parameters for the procurement of health goods, and fraud and risk management.

(2) Health care service providers and health establishments must submit such information as may be prescribed to the fund, taking into consideration the provisions of the Protection of Personal Information Act.

(3) The information in subsection (2) may be used by the fund to:

(a) monitor health care service utilisation and expenditure patterns relative to plans and budgets;

(b) plan and budget for the purchasing of quality personal health care services based on the needs of beneficiaries;

(c) monitor adherence to standard treatment guidelines, including prescribing from the Formulary;

(d) monitor the appropriateness and effectiveness of referral networks prescribed by health care service providers and health establishments;

(e) provide an overall assessment of the performance of health care service providers, health establishments and suppliers; and

(f) determine the payment mechanisms and rates for personal health care services.

(4) Information concerning a ~~user~~ beneficiary, including information relating to his or her health status, treatment or stay in a health establishment, is confidential and no-one ~~third party~~ may disclose information contemplated in subsection (2), unless:

(a) the ~~user~~ beneficiary consents to such disclosure in writing; or

(b) the information is shared among health care service providers for the lawful purpose of serving the interests of the beneficiary ~~users~~; or

(c) the information is required by a~~n accredited~~ contracted health care service provider, health establishment, or supplier or researchers for the lawful purpose of improving health care practices and policy~~, but not for commercial purposes~~; or

(d) the information is utilised by the fund for any other lawful purpose related to the efficient and effective functioning of the fund; or

(e) a court order or any law requires such disclosure. ~~or~~

~~*(f)* failure to disclosure the information represents a serious threat to public health.~~ **This is a repetition of the NHA**

(5) The information ~~architecture~~ system must include a mechanism for the detection of fraud, waste and abuse involving health care resources and a risk management mechanism.

(6) In order to fulfil the requirements for dissemination of information and the keeping of records, the information ~~platform~~ system must facilitate:

(a) the implementation of the objects and the effective management of the fund; and

(b) ~~portability and~~ continuity of health care services available to beneficiaries ~~users~~ subject to the provisions of this Act.

Payment of health care service providers

~~41~~38. (1) The fund~~, in consultation with the Minister,~~ must determine the nature of health care service provider and supplier payment mechanisms. ~~and adopt additional mechanisms.~~

(2) The fund must ensure that health care service providers, health establishments and suppliers are properly ~~accredited~~ certified before they are paid ~~reimbursed~~.

~~(3) *(a)* An accredited primary health care service provider must be contracted and remunerated by a Contracting Unit for Primary Health Care.~~

(3) *(b)* In the case of specialist and hospital services, payments must be all-inclusive and based on the performance of the service provider, establishment or supplier of health goods, as the case may be.

(c) Emergency medical services must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.

(4) Without limiting the powers of the Minister to make regulations in terms of section 525, the Minister may make regulations to that:

(a) provide that payments by the fund may be made on condition that there has been compliance by health care providers or suppliers with quality and other standards prescribed under the NHA of care or the achievement of specified levels of performance;

(b) determine mechanisms for the payment of an individual health worker and health care provider; and

(c) provide that the whole or any part of a payment is subject to the conditions outlined in a contract and that payments must only be effected by the fund if the conditions have been met. **(This is a contractual term that must be expressed in the contract, not regulations)**

(5) For the purposes of subsection (4), "health worker" and "health care provider" have the meanings ascribed to them in section 1 of the NHA.

Complaints

4239. (1) An affected natural or juristic person, namely a user beneficiary, health care service provider, health establishment or supplier, may furnish a complaint with to the fund in terms of the complaints procedures determined by the fund; in consultation with the Minister; the fund must deal with such complaints in a timeous and transparent manner. and in terms of the law.

(2) The Investigating Unit established by the Chief Executive Officer in terms of 25 section 20(2)*(e)* unit of the fund responsible for dealing with complaints must, launch within 30 days of receipt of the complaint, conduct an investigation to establish the facts of the incident reported complaint and make recommendations to the chief executive officer as to how the matter may be resolved within 30 days of receipt of the complaint.

(3) The complainant must be informed in writing of the outcome of the investigation ~~launched~~ conducted in terms of subsection (2), and any decision taken by the fund, within a reasonable period of time.

(4) If the complaint relates to a health care service provider or supplier, the fund must, before taking a decision on the complaint:

(a) provide the health care service provider or supplier, as the case may be, ~~with a notice of the decision to provide the health care service provider~~ with a reasonable opportunity to make representations in respect of such a ~~a decision~~ complaint;

(b) consider the representations made in respect of paragraph *(a)*; and

(c) provide adequate written reasons for its decision regarding the complaint to the health care service provider to whom the complaint relates. ~~the decision to withdraw or refuse the renewal of accreditation to the health care service provider, as the case may be.~~

Lodging of appeals

4~~3~~0. A natural or juristic person, namely a ~~user~~ beneficiary, health care service provider, health establishment or supplier aggrieved by a decision of the fund ~~delivered~~ made in terms of section ~~42~~ 39 may, within a period of 60 days after receipt of written notification of the decision, appeal against such decision to the appeal tribunal.

Appeal tribunal

41. (1) An appeal tribunal is hereby established, consisting of five persons appointed by the Minister:

(a) One member appointed on account of his or her knowledge of the law, who must also be the chairperson of the board;

(b) two members appointed on account of their medical knowledge; and

(c) two members appointed on account of their financial knowledge.

(2) A member of the appeal tribunal appointed by the Minister in subsection (1) must serve as a member for a period of three years, which term is renewable only once.

(3) A member ceases to be a member if:

(a) he or she resigns from the appeal tribunal;

(b) the Minister terminates his or her membership on good cause; or

(c) the term for which the member was appointed has expired and has not been renewed, or after a second term when it may not be renewed.

Powers of appeal tribunal

42~~5~~. (1) The appeal tribunal has the same power as a High Court to:

(a) summon witnesses;

(b) administer an oath or affirmation;

(c) examine witnesses; and

(d) call for the discovery of documents and objects.

(2) The appeal tribunal may after hearing the appeal:

(a) confirm, set aside or vary the relevant decision of the fund; or

(b) order that the decision of the fund be effected.

Secretariat

43~~6~~. The chief executive officer of the board must designate a staff member of the fund to act as secretary of the appeal tribunal and the fund must keep the minutes and all records of a decision of the ~~board~~ tribunal for a period of at least three years after the decision has been recorded.

Procedure and remuneration

44~~7~~. (1) The Minister, in consultation with the Minister of Finance and the fund, must determine the terms, conditions, remuneration and allowances applicable to the members of the appeal tribunal.

(2) A member of the tribunal must recuse him- or herself if it transpires that he or she has any direct or indirect personal interest in the outcome of the appeal and must be replaced for the duration of the hearing by another person with similar knowledge appointed by the Minister.

(3) The tribunal must determine the outcome of the appeal within 180 days of the lodging~~ement~~ of the appeal and inform the appellant of the decision in writing. The secretariat appointed in terms of section 43~~6~~ must keep records of all proceedings and outcomes.

(4) Nothing in this section precludes an aggrieved party from seeking suitable redress in a court of law that has jurisdiction to hear such a matter.

Sources of funding

485. The revenue sources for the fund consist of:

(a) money to which the fund is entitled in terms of section 469;

(b) any fines imposed in terms of this Act other than by a court of law;

(c) any interest or return on investment made by the fund;

~~*(d)* any money paid erroneously to the fund which, in the opinion of the Minister, cannot be refunded;~~

(e) any bequest or donation received by the fund; and

(f) any other money to which the fund may become legally entitled.

Chief source of income

496. ~~(1)~~ The fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act.

~~(2) The money referred to in subsection (1) must be—~~

~~*(a)* appropriated from money collected and in accordance with social solidarity in respect the form of—~~

~~(i) general tax revenue, including the shifting funds from the provincial equitable share and conditional grants into the fund;~~

~~(ii) reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance;~~ **(Note: Tax credits are not paid to medical schemes.)**

~~(iii) payroll tax (employer and employee); and or~~

~~(iv) surcharge on personal income tax,~~

~~introduced through in accordance with a money Bill as contemplated in section 77 of the Constitution by the Minister of Finance and earmarked for use by the fund, subject to section 57; and~~

~~*(b)* calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.~~

~~(3) Once appropriated, the revenue allocated to the fund must be paid through a Budget Vote to the fund as determined by agreement between the fund and the Minister and subject to the provisions of the Constitution and the Public Finance Management Act.~~ (**Note: The deleted portions of this section belong in a money bill).**

Auditing

47~~50~~. The Auditor-General must audit the accounts and financial records of the fund annually as ~~outlined~~ set out in the Public Audit Act (Act No. 25 of 2004).

Annual reports

48~~51~~. (1) As the accounting authority of the fund, the board must submit to the Minister and Parliament a report on the activities of the fund during a financial year ~~as determined~~ in terms of ~~by~~ the Public Finance Management Act.

(2) Subject to the provisions of the Public Finance Management Act, the report must include:

(a) the audited financial statements of the fund;

(b) a report of activities undertaken in terms of its functions set out in this Act;

(c) a statement of the progress achieved during the preceding financial year towards realisation of the purpose of this Act; and

(d) any other information that the Minister, by notice in the *Gazette*, determines.

(3) In addition to the matters which must be included in the annual report and financial statements as determined by section 55 of the Public Finance Management Act, the annual report must be prepared in accordance with generally accepted accounting practice and contain a statement showing:

(a) the total number of ~~users~~ beneficiaries who received health care benefits in terms of this Act;

(b) the total monetary value of health care benefits provided in respect of each category of benefits and level of care as determined by the Minister;

(c) all loans, overdrafts, advances and financial commitments of the fund;

(d) the particulars of all donations and bequests received by the fund;

(e) an actuarial valuation report;

(f) particulars of the use of all immovable and movable property acquired by the fund;

(g) any amount written off by the fund; and

(h) any other matter determined by the Minister.

(4) The Minister must without delay:

(a) table a copy of the report in the National Assembly; and

(b) submit a copy of the report to the National Council of Provinces.

Assignment of duties and delegation of powers

49~~52.~~ Subject to the Public Finance Management Act:

(a) the Minister may assign any duty and delegate any power imposed or conferred upon him or her by this Act, except the power to make regulations, to any person in the employ of the fund; and

(b) the chief executive officer of the fund may assign any duty and delegate any power imposed or conferred upon him or her by this Act to any employee of the fund.

Protection of confidential information

50~~53~~. Nothing in this Act affects the provisions in any other legislation or law prohibiting or regulating the processing or disclosure of personal or other sensitive information accessible to or in possession of the fund.

Offences and penalties

51~~54~~. (1) Any person who:

(a) knowingly submits false information to the fund or its agents;

(b) makes a false representation with the intention of obtaining health care service benefits from the fund to which he or she is not entitled;

(c) utilises money paid from the fund for a purpose other than that in respect of which it is paid;

(d) obtains money or other gratification from the fund under false pretences; or

(e) sells or otherwise discloses information owned by the fund to a third party without the prior knowledge and written consent of the fund

is guilty of an offence and liable on conviction in a court of law to a fine not exceeding R100 000.00 or imprisonment for a period not exceeding five years or to both a fine and such imprisonment.

(2) Any natural or juristic person who fails to furnish the fund or an agent of the fund with information required by this Act or any directive issued under this Act within the prescribed or specified period or any extension thereof, irrespective of any criminal proceedings instituted under this Act, must pay a prescribed fine for every day which the failure continues, unless the fund, on good cause shown, waives the fine or any part thereof.

(3) Any penalty imposed under subsection (2) is a debt due to the fund.

Regulations

52~~55~~. (1) ~~Without derogating from the powers conferred on the Minister by the Constitution and the NHA or any other applicable law,~~**(Note: Unnecessary wording)** ~~t~~The Minister may, after consultation with the fund ~~and the National Health Council contemplated in section 22 of the NHA,~~ and, with regard to regulations made in terms of sub-paragraphs (b),(i),(n),(o),(p) and (q) below, in consultation with the Prudential Authority make regulations regarding: **(Note: The National Health Council consists of provincial departments of health and MECs who are all on the provider side of the purchaser/provider split. They should not have any opportunities to regulate the fund or have a say in how it is regulated because the fund is the purchaser.)**

(a) the ~~legal~~ relationship between the fund and the various categories of health establishments, health care service providers or suppliers ~~as provided for in the NHA~~;

~~*(b)* payment mechanisms to be employed by the fund in order to procure health care services from accredited and contracted health care service providers, health establishments or suppliers;~~ **(Note: The fund must be free to determine the best and most efficient payment mechanisms and these may change with time. They should not be written into law.)**

(b) the budget of the fund, including the processes to be followed in drawing up the budget, in compliance with the provisions of the Public Finance Management Act;

(c) information to be provided to the fund for the development and maintenance of the national health information system by beneficiaries ~~users~~, health establishments, health care service providers or suppliers and the format in which such information must be provided;

(d) clinical information and diagnostic and procedure codes to be submitted to the fund and used by health care service providers, health establishments or suppliers for reimbursement and reporting purposes ~~to the fund~~;

(e) participation by the ffund in the national health information system contemplated in section 74 of the NHA, including the Health Patient Registration System referred to in section 369 of this Act;

(f) the registration of beneficiaries ~~users~~ of the fund in terms of section 5;

~~*(h)* the accreditation of health care service providers, health establishments or suppliers;~~

~~*(i)* the functions and powers of a District Health Management Office;~~

~~*(j)* the functions and powers of a Contracting Unit for Primary Health Care Services;~~

(g) the relationship between the fund and the Office of Health Standards Compliance;

(h) the relationship between the fund and the Department of Correctional Services in order to clarify the mechanisms for purchasing, within available resources, quality needed personal health care services for inmates as required by the Correctional Services Act (Act No. 111 of 1998);

~~*(m)* the relationship between public and private health establishments; and the optional contracting in of private health care service providers;~~ **(This is already provided for in section 45 of the NHA.)**

(i~~n~~) the relationship between the fund and medical schemes registered in terms of the Medical Schemes Act and other private health insurance providers; ~~schemes;~~

(j~~o~~) the development and maintenance of the Formulary;

(*k~~p~~*) investigations to be conducted by the fund or complaints against the fund in order to give effect to the provisions of Chapter 8;

(l~~q~~) appeals against decisions of the fund in order to give effect to the provisions of Chapter 8;

(mr) the manner in which health care service providers, health establishments and suppliers must report to the fund in respect of health care services or health goods purchased by the fund and the content of such reports;

(ns) the monitoring and evaluation of the performance of the fund;

(ot) ~~all~~ fees payable by or to the fund;

(pu) subject to the Public Finance Management Act, the nature and level of reserves to be kept within the fund;

(qv) subject to the Public Finance Management Act, the manner in which money within the fund must be invested;

(rw) ~~all~~ practices and procedures to be followed by a health care service provider, health establishment or supplier in relation to the fund;

~~*(x)* the scope and nature of prescribed health care services and programmes and the manner in, and extent to which, they must be funded;~~

(sy) the proceedings of the meetings of committees appointed by the Minister in terms of this Act and a code of conduct for members of those committees;

(tz) the proceedings and other related matters of the appeal tribunal;

(uzA) any matter that may or must be prescribed in terms of this Act; and

(vzB) any ancillary or incidental administrative or procedural matter that may be necessary for the proper implementation or administration of this Act.

(2) The Minister must, not less than three months before any regulation is made under subsection (1), ensure that a copy of the proposed regulation is published in the *Gazette* together with a notice declaring his or her intention to make that regulation and inviting interested persons to furnish him or her with their comments thereon or any representations they may wish to make in regard thereto.

(3) The provisions of subsection (2) do not apply in respect of:

(a) any regulation made by the Minister which, after the provisions of that subsection have been complied with, has been amended by the Minister in consequence of comments or representations received by him or her in pursuance of a notice issued thereunder; or

(b) any regulation which the Minister, after consultation with the board, deems in the public interest to publish without delay.

(4) Regulations must be tabled in the National Assembly and the National Council of Provinces for a period of one month before being finalised.

Directives

53~~6~~. (1) The fund may issue directives regarding the implementation and administration of this Act which must ~~be complied with in the implementation and administration of this Act~~, ~~and any directives so issued must~~ be published in the *Gazette*. (**The fund does not have the power to make law and so the directives must not have the status of law.)**

(2) Any directive issued under this section may be amended or withdrawn in like manner.

Oversight of the fund

54. The Prudential Authority established in terms of the Financial Sector Regulations Act (Act No. 9 of 2017) must exercise oversight of the fund by:

(1) regulating and supervising the fund in a manner that promotes and enhances the safety and soundness of the fund;
(2) protecting beneficiaries of the fund against the risk of unfunded mandates on the part of the fund;
(3) issuing directives to the fund and setting standards regarding the efficient and effective financial management of the fund including, but not limited to, financial risk management, financial asset management and financial reporting of the fund;
(4) identifying and monitoring the level of reserves the fund must maintain in order to ensure its sustainability;
(5) regularly reviewing the perimeter and scope of the regulatory environment of the fund in order to identify and mitigate risks to the sustainability and financial stability of the fund;
(6) conducting and publishing research relevant to financial matters affecting the fund;
(7) advising the Minister on the appropriate measurement of the financial performance of the fund and recommending regulations that will ensure the stability and sustainability of the fund;
(8) annually submitting a written report to Parliament on the financial performance of the fund including the financial risks to which the fund is exposed and methods for the effective mitigation of such risks.

(Note: It is essential that there be adequate and responsible oversight of the fund's financial affairs and risks by an independent and expert entity outside of the fund. The Prudential Authority is already responsible for the financial stability and sustainability of financial institutions in South Africa in terms of the Financial Sector Regulation Act. It makes sense to give it the responsibility of oversight of the fund because it will have the necessary skills and expertise to do this better than any other organ of state)

~~**Transitional arrangements**~~ **(Note: It is not appropriate to include the following transitional arrangements in legislation. They belong in a policy document and are for information purposes only. It is compulsory to comply with a law. Plans for the implementation of a law are not compulsory and so should not be included in the law itself.)**

~~**57.** (1) *(a)* Despite anything to the contrary in this Act, this Act must be implemented over two phases.~~

~~*(b)* National Health Insurance must be gradually phased in using a progressive and programmatic approach based on financial resource availability. 55~~

~~(2) The two phases contemplated in subsection (1) *(a)* are as follows:~~
~~*(a)* Phase 1, for a period of five years from 2017 to 2022 which must—~~

~~(i) continue with the implementation of health system strengthening initiatives, including alignment of human resources with that which may be required by users of the fund;~~

~~(ii) include the development of National Health Insurance legislation and amendments to other legislation;~~

~~(iii) include the undertaking of initiatives which are aimed at establishing institutions that must be the foundation for a fully functional fund; and~~

~~(iv) include the purchasing of personal health care services for vulnerable groups such as children, women, people with disabilities and the elderly; and~~

~~*(b)* Phase 2 must be for a period of four years from 2022 to 2026 and must include—~~

~~(i) the continuation of health system strengthening initiatives on an on-going basis;~~

~~(ii) the mobilisation of additional resources where necessary; and~~

(iii) the selective contracting of health care services from private providers.

(3) In Phase 1 the Minister may establish the following interim committees to advise him or her on the implementation of the National Health Insurance:

(a) The National Tertiary Health Services Committee which must be responsible for developing the framework governing the tertiary services platform in South Africa.

(b) The National Governing Body on Training and Development which must, amongst others—

(i) be responsible for advising the Minister on the vision for health

workforce matters, for recommending policy related to health sciences, student education and training, including a human resource for health development plan;

(ii) be responsible for the determination of the number and placement of (including but not limited to) all categories of interns, community service and registrars;

(iii) oversee and monitor the implementation of the policy and evaluate its impact; and

(iv) coordinate and align strategy, policy and financing of health sciences education.

(c) The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance, which must be a precursor to the Benefits Advisory Committee and which must advise the Minister on a process of priority-setting to inform the decision-making processes of the fund to determine the benefits to be covered.

(d) The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance, which must be established to advise the Minister on Health Technology Assessment and which must serve as a precursor to the Health Technology Assessment agency that must regularly review the range of health interventions and technology by using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and Health Technology Assessment.

(4) Objectives that must be achieved in Phase 1 include—

(a) the migration of central hospitals that are funded, governed and managed nationally as semi-autonomous entities;

~~*(b)* the structuring of the Contracting Unit for Primary Health Care at district level in a cooperative management arrangement with the district hospital linked to a number of primary health care facilities;~~

~~*(c)* the establishment of the fund, including the establishment of governance structures;~~

~~*(d)* the development of a Health Patient Registration System contemplated in section 5;~~

~~*(e)* the process for the accreditation of health care service providers, which must require that health establishments are inspected and certified by the Office of Health Standards Compliance, health professionals are licensed by their respective statutory bodies and health care service providers comply with criteria for accreditation;~~

~~*(f)* the purchasing of health care service benefits, which include personal health services such as primary health care services, maternity and child health care services including school health services, health care services for the aged, people with disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists and other designated providers at a primary health care level focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs;~~

~~*(g)* the purchasing of hospital services and other clinical support services, which must be—~~

~~(i) funded by the fund;~~

~~(ii) an expansion of the personal health services purchased; and~~

~~(iii) from higher levels of care from public hospitals (central, tertiary, regional and district hospitals) including emergency medical services and pathology services provided by National Health Laboratory Services; and~~

~~*(h)* the initiation of legislative reforms in order to enable the introduction of 15 National Health Insurance, including changes to the—~~

~~(i) Medicines and Related Substances Act, 1965 (Act No. 101 of 1965);~~

~~(ii) Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of~~

~~1973);~~

~~(iii) Health Professions Act, 1974 (Act No. 56 of 1974); 20~~

~~(iv) Dental Technicians Act, 1979 (Act No. 19 of 1979);~~

~~(v) Allied Health Professions Act, 1982 (Act No. 63 of 1982);~~

~~(vi) Medical Schemes Act, 1998 (Act No. 131 of 1998);~~

~~(vii) Mental Health Care Act, 2002 (Act No. 17 of 2002);~~

~~(viii) NHA; 25~~

~~(ix) Nursing Act, 2005 (Act No. 33 of 2005);~~

~~(x) Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007); and~~

~~(xi) other relevant Acts.~~

~~(5) Objectives that must be achieved in Phase 2 include the establishment and operationalisation of the fund as a purchaser of health care services through a system of 30 mandatory prepayment.~~

Repeal or amendment of laws

55~~58~~. (1) Subject to this section ~~and section 57 dealing with transitional arrangements,~~the laws mentioned in the second column of the schedule are hereby repealed or amended to the extent set out in the third column of the schedule.

(2) The repeal or amendment of any law by this Act does not affect:

(a) the previous operation of such law or anything done or permitted under such law;

(b) any right, privilege, obligation or liability acquired, accrued or incurred under such law; or

(c) any penalty, forfeiture or punishment incurred in respect of any offence committed in terms of such law.

Short title and commencement

56~~59~~. (1) This Act is called the National Health Insurance Act, 2019, and takes effect on a date fixed by the President by proclamation in the Government *Gazette*.

(2) ~~Subject to section 57,~~ dDifferent dates may be fixed in respect of the coming into effect of different provisions of this Act.

FURTHER NOTES ON THE SCHEDULE TO THE BILL

1. **The proposed amendment in the schedule of the bill to the Medicines and Related Substances Act must stipulate that the single exit price is the maximum price that anyone may be charged for medicines;**
2. **The proposed amendments to the Medical Schemes Act must be deleted as they are unconstitutional and not relevant to NHI. There is already a process under way for a complete review of the Medical Schemes Act. The Medical Schemes Amendment Bill was published in 2018 and the regulator said it would wait for the HMI report to be finalised before continuing with it.**
3. **The proposed amendments to the NHA creating DHMOs and CUPHCs must be deleted from the schedule to the bill. The provincial health departments and the municipalities and district health councils created in the NHA must play the roles assigned to these entities. DHMOs and CUPHCs will just add unnecessarily to the costs of NHI without adding any value and don't fit into our constitutional system.**